

Unequally Uninsured:  
Safety-Net Healthcare Delivery and the Reproduction of Inequality

by

Collin William Mueller

Department of Sociology  
Duke University

Date: \_\_\_\_\_

Approved:

\_\_\_\_\_  
Linda M. Burton, Co-Supervisor

\_\_\_\_\_  
Linda K. George, Co-Supervisor

\_\_\_\_\_  
Eduardo Bonilla-Silva

\_\_\_\_\_  
Jessi Streib

Dissertation submitted in partial fulfillment of  
the requirements for the degree of Doctor  
of Philosophy in the Department of  
Sociology in the Graduate School  
of Duke University

2017

Unequally Uninsured:  
Safety-Net Healthcare Delivery and the Reproduction of Inequality

by

Collin William Mueller

Department of Sociology  
Duke University

Date: \_\_\_\_\_

Approved:

\_\_\_\_\_  
Linda M. Burton, Co-Supervisor

\_\_\_\_\_  
Linda K. George, Co-Supervisor

\_\_\_\_\_  
Eduardo Bonilla-Silva

\_\_\_\_\_  
Jessi Streib

An abstract of a dissertation submitted in partial  
fulfillment of the requirements for the degree  
of Doctor of Philosophy in the Department of  
Sociology in the Graduate School of  
Duke University

2017

Copyright by  
Collin William Mueller  
2017

## **Abstract**

This dissertation explores how low-income and uninsured adults' everyday experiences of inequality shape both the healthcare they have access to and the ways in which they navigate safety-net healthcare organizations in the years following the passage of the Affordable Care Act (ACA). Low-income and uninsured adults in the U.S. are the leading edge in the rising incidence of preventable chronic illness and are in need of high-quality preventive healthcare. However, social scientists have made little progress in understanding the role of healthcare safety-net organizations in the lives of low-income and uninsured adults as they traverse these settings amid everyday experiences of economic insecurity, pressing health needs, and interlocking systems of oppression in an era characterized by significant health and welfare policy changes, neoliberal privatization, and safety net resource fragmentation.

The three studies in this dissertation advance this area of research by systematically analyzing multiple data sources centered on the perceptions and experiences of safety net healthcare workers and low-income and uninsured patients as they navigate a private primary care clinic in a mid-sized city in the southeastern U.S. which has become a New Immigrant Destination. In these studies, I explore the ways low-income and uninsured adults navigate a private nonprofit primary care safety net clinic and manage chronic health conditions amid everyday experiences of poverty and

uncertainty. The first study explores how organizational features structuring patient eligibility and intake processes may exacerbate or lessen inequality among new patients as they enter primary care treatment in a private clinic in the healthcare safety net. The second study explores worker agency and offers a conceptual model to understand linkages between worker rule-breaking behaviors oriented to provide more equitable patient treatment or possibly harm patients, when and how organizational change occurs, patient background characteristics, and long-term patient health outcomes. The third study explores how individuals in one disadvantaged group, unauthorized Latina mothers, undertake strategies to combat cumulative health disadvantage as they access health-promoting safety net resources and traverse everyday social and economic hardships, uncertainty, and deportation threat.

# Table of Contents

Abstract .....	iv
List of Tables .....	x
List of Figures .....	xi
Acknowledgements .....	xii
1. Introduction .....	1
1.1 Theoretical Background.....	3
1.2 Overview of Empirical Chapters.....	6
2. Becoming a Patient at a Private Primary Care Safety-Net Clinic.....	10
2.1 Abstract .....	10
2.2 Introduction.....	11
2.3 Theoretical Background.....	13
2.3.1 Class Heterogeneity among Low-Income Uninsured Adults.....	13
2.3.2 The Role of Safety Net Organizations in Cumulative Health Disadvantage....	17
2.4 Data and Methods .....	20
2.4.1 Overview of the study .....	20
2.4.2 Field site.....	21
2.4.3 Recruitment and sample description.....	23
2.4.4 Data sources, coding, and analysis .....	25
2.5 Findings .....	27
2.5.1 The Front Door: Playing by the Rules of the Safety Net.....	28

2.5.2 The Back Door: Skipping the Line via Emergency Department Referrals .....	34
2.5.3 The Side Door: Safety-Net Handoffs and Relaxed Eligibility Restrictions .....	38
2.6 Discussion.....	41
3 Street-Level Rule Breaking and Organizational Transformation: A Conceptual Model .....	47
3.1 Abstract .....	47
3.2 Introduction.....	48
3.3 Background .....	53
3.3.1 Safety Net Organizational Resource Environments following Welfare Reform .....	54
3.3.2 Theorizing Institutional Logics and Organizational Change in New Destination Safety Net Healthcare Settings.....	56
3.3.3 Conceptual Model and Ethnographic Approach.....	61
3.4 Workplace Context and Racial Resistance: Patient Needs, Workplace Culture, Social Capital, and Precarious Bureaucratic Structures .....	66
3.4.1 Patient Needs .....	67
3.4.2 Workplace culture: intersecting institutional logics, racial ideologies, and cultural schemas .....	67
3.4.2.1 Institutional logics.....	68
3.4.2.2 Ideologies and schemas.....	69
3.4.2.3 Social Capital .....	72
3.4.2.4 Precarious Bureaucratic Structures .....	73
3.4.3 Organizational Routines, Resistance, and Change .....	76
3.4.3.1 Regular Resistance .....	76

3.4.3.2 Creative Resistance .....	81
3.4.3.3 Collaborative Resistance .....	83
3.4.4 Patient Characteristics .....	86
3.4.5 Life Course Consequences of Organizational Responses to Resistance .....	86
3.4.5.1 Life Course Consequences of Creative Resistance: Radically Altered Trajectories in Exceptional Circumstances .....	87
3.4.5.2 Re-Coupling Resistance to Create a “Framing Institution” .....	89
3.5 Discussion.....	93
3.5.1 Precarious organizations and organizational change in a New Immigrant Destination .....	94
3.5.2 Safety net usage as a life course "event" .....	95
4 Unauthorized, Uninsured, and Undeterred: Latina Mothers' Strategies for Combatting Cumulative Health Disadvantage .....	98
4.1 Abstract.....	98
4.2 Introduction.....	99
4.3 Background .....	100
4.3.1 Theorizing immigration policy and cumulative health disadvantage .....	100
4.3.2 Safety net usage as a life course “event” .....	102
4.4 Data and Methods .....	106
4.4.1 Overview of the study .....	106
4.4.2 Recruitment and sample description.....	106
4.4.3 Data sources, coding, and analysis .....	107
4.5 Findings .....	109



4.5.1 Remembering life course trauma and everyday hardships .....	109
4.5.2 Navigating, rationing, and sacrificing resources to secure family well-being	112
4.5.3 Coping with adversity and hoping for the future .....	115
4.6 Discussion.....	125
4.6.1 Healthcare usage and cumulative disadvantage processes .....	125
4.6.2 Multidimensionality in healthcare seeking strategies.....	126
4.6.3 Frailties, resilience, and managing treatments and risks.....	128
4.6.4 Study limitations and additional areas for future research.....	130
4.6.5 Implications for organizational practice and social policy.....	135
5 Conclusion .....	137
Appendix A: Worker Interview Guide .....	143
Appendix B: Patient Interview Guide.....	145
References .....	153
Biography.....	167

## List of Tables

Table 1: Patient Interview Respondents .....	25
--	----

## List of Figures

Figure 1: A Conceptual Model Linking Racial/Ethnic Resistance, Organizational Change, Patient Characteristics, and Life Course Consequence .....	63
--	----

## Acknowledgements

First I would like to thank my parents, Kim and Charles Mueller, for raising me in an environment that encouraged curiosity, hard work, independence, and creativity. Without that foundation, none of this would have been achievable. I'd also like to thank my incredible sister, Kristen Jones, for growing with me, putting up with me, and making me into a more well-rounded person. Next I'd like to thank my best friend and partner in life Jenna Mueller for providing constant encouragement and for journeying with me over the past twelve years. To the rest of the Mueller, Berman, and Hook family, thank you for being love-filled grandparents, aunts and uncles, cousins, and in-laws. To my friends and community, thank you for your support and laughter.

Next I'd like to thank my committee members, who have guided and encouraged me along the way. Eduardo Bonilla-Silva, thank you for taking me under your wing early on and for constantly pushing the horizons of my sociological imagination and in my life on the ground. Jessi Streib, I am grateful for your constant encouragement, methodological guidance, and hard questions. Linda George and Linda Burton, this would've not been possible without your guidance and mentoring at every step along the way. It is no wonder that you each have a reputation as an award-winning mentor. Together, as "Linda Squared," you are a total institution! You have been key "framing agents" for me, transforming my formation as a scholar and filling me with hope. You

have taught me so much about scholarship and life, and words cannot do justice to how grateful I am for the blessing you've been in my life. The attention, kindness, and generosity that each of you — Eduardo, Jessi, Linda G, and Linda B — commit to your students is truly an inspiration that I hope to emulate in the future.

# 1. Introduction

While low-income uninsured adults in the U.S. represent a leading edge in the rising incidence of preventable chronic conditions and are in need for high-quality preventive healthcare interventions (Zhang 2012; Ayanian 2000; Vaidya et al. 2011), social scientists have made little progress in understanding what is happening on the ground and in the daily lives of uninsured patients as they navigate the healthcare safety net. How are these preventive healthcare encounters created, situated, and experienced in contemporary American society? How are they shaped by low-income and uninsured adults' attitudes, feelings, and expectations about the healthcare safety net? What social and economic advantages and disadvantages do uninsured adults accumulate over the life course that influence the courses-of-action they take in their healthcare usage, and how are these strategies shaped by interactions with healthcare safety net organizations?

These questions and others have been ardently raised by medical sociologists and demographers who are seeking explanations for why access to preventive healthcare and related medical encounters among uninsured adults (as well as the broader American population) have become so diverse and now require, more than ever, innovative and perhaps unconventional approaches to address current gaps in knowledge about the forces driving and characterizing these encounters (Holden et al. 2015). Indeed, the need for unpacking preventive healthcare encounters, particularly

among low-income adults in safety net healthcare organizational settings, has been hastened by the sheer magnitude of change and growing variability in prevailing types of health insurance coverage, preventive healthcare access and usage, and the distribution of healthcare resources through public and private nonprofit safety-net organizations. Adequately addressing that need, however, has also been stalled in some ways by the field's traditional approach of studying disadvantaged African American patients covered by Medicaid to identify and to develop normative descriptions about what might be "going on" among low-income patient populations navigating contemporary healthcare settings.

Although some have called for researchers to pay closer attention to the role of place in shaping population-level health disparities (White et al. 2012), rarely do researchers investigate how preventive healthcare is understood and experienced by workers and patients together in particular settings. In fact, recent empirical work on access to and use of preventive healthcare among the uninsured is frequently relegated to studies of the effects of macro influences, such as urban neighborhood poverty, residential segregation, or patterns of safety-net exclusion (Sandri et al. 2014; Laiteerapong et al. 2014; Chan et al. 2012; Stone et al. 2015), or to documenting correlations between lack of health care coverage and poor health outcomes (Zhang et al. 2012) or disparities in preventive service usage rates among the uninsured (Holden et al. 2015).

To be sure, this brief overview of extant research on uninsured adults' preventive healthcare access and usage is not comprehensive. It is, however, suggestive of the reality that we know far less than we should, at this point in historical time, about the dynamic and nuanced features operating in the preventive healthcare experiences of the uninsured. Therefore, the significance of the proposed project is the new knowledge it will generate and contribute to scholarly discourse about what is going on inside uninsured patients' encounters with the healthcare safety net.

### ***1.1 Theoretical Background***

This dissertation is guided by symbolic interaction theory, life course cumulative disadvantage approaches, research on organizational processes and the healthcare safety net, and an emerging body of research on race relations in New Immigrant Destinations. From symbolic interaction theory I rely on Blumer's (1955) conceptual discussions about attitudes. He pointed out that human action (e.g., seeking preventive healthcare at a private or public safety net clinic) is not an automatic response to general attitudes. Rather, actors construct courses of action based on their consideration of factors particular to situations. While a general attitude may have some bearing on the actor's decision to behave in one way or another, it represents, as Blumer cautioned, "merely an element that enters into the developing acts—no more than an initial bid for a possible line of action" (1955, p. 63). Blumer (1955, p. 64) stated that to fully understand human actions, one must "get inside individuals' frameworks of operation," identifying how



they distinguish situational dimensions that are important to their actions, and how they piece those dimensions together in deciding how to act. Thus, in the analyses conducted in this dissertation I make distinctions between how general attitudes, feelings, and expectations shape healthcare safety net encounters compared to processes that are situationally based. I do so by carefully considering what individuals say about their experiences as well as what they actually do. I also seek to be mindful of how respondents' impression management practices influence public representations of their attitudes, feelings, and expectations (following Horton 2006; Goffman 1959).

I apply a cumulative advantage/disadvantage perspective to these analyses (see Dannefer 1987, 2003; DiPrete and Eirich 2006) in investigating how life course and organizational processes shape experiences of the healthcare safety net. The social stratification literature often uses cumulative advantage theory to explain inequality in status or achievement over time. I, however, adapt it to study healthcare safety net outcomes. The central claim of this theory is that *a favorable relative position generates gains across the life course, resulting in the growth of the advantage of one individual or group relative to another across time*. This perspective further posits that the various trajectories that are evident later in life originate from early inequalities. Individuals who begin in a position of advantage maintain this relative standing and even experience increased gains as they age, while those who are subject to disadvantage in childhood face a further accumulation of risk factors that amplify their disadvantaged status over time.

With respect to how prior research on organizational processes shape my investigation of the healthcare safety net, I begin by applying theoretical insights from research on institutional logics and complex organizations (Thorton et al. 2012; Perrow 1986; Hasenfeld 2010). I integrate these efforts with prior research on the performance of race and gender in workplace settings (following West and Zimmerman 1987; Jackson 2001; Warren 2001; Markus and Moya 2010; Wingfield 2009, 2013). I acknowledge that most extant research on the healthcare safety net focuses on demographic descriptions of the prevalence and correlates of low-income patients' reliance on the healthcare safety net and the impact of safety net healthcare usage on health outcomes among the poor (Heintzman et al. 2014; Bradley et al. 2015). There are, however, a few processes that have been studied in social environments relevant to the healthcare safety net, such as "street-level" welfare officers "shaping the form, content, and discourse around service delivery to reflect their investments, anxieties, and visions for both policy and the world around them" (Watkins-Hayes 2009 p. 192; see also Horton 2006) and workers racializing the population of social safety net clients (Watkins-Hayes 2009) and patients (Bridges 2011) through bureaucratic routines and everyday interactions. Hasenfeld (2010) theorizes that human service organizations are social settings uniquely characterized by the importance of client-worker relations, emotional labor, and the prevalence of women as human care workers. However, racial inequality has typically been a focus of individual-level mechanisms in organizations research, and detailing the

meso-level mechanisms that contribute to racial inequality is an under-developed area (Reskin 2000; Wingfield and Alston 2014). By investigating the reproduction of inequality in relation to organizational processes at Compassion Health Clinic (CHC), this dissertation research directly addresses this gap.

The analyses conducted in this dissertation enable an examination of how structural contextual features shape safety net usage as a life course “event” and situate meso-level organizational mechanisms within broader structural characteristics of a New Immigrant Destination (NID) setting. A small but growing body of ethnographic research has explored how poor Latino families experience race relations in NIDs (Marrow 2009; Gómez and López 2013) and the impact of unauthorized immigration status on family well-being (Gonzales 2011; Abrego 2011). I build on recent insights in this area of research by investigating the perspectives and experiences of Latina/os as they encounter safety net healthcare organizations in the wake of the partial implementation of the Affordable Care Act (a previously unexplored empirical domain), and by developing sociological theory linking meso-level organizational processes with macro-level contextual features of the NID setting.

## ***1.2 Overview of Empirical Chapters***

Chapter 2 reports a systematic investigation of how transitions around health, family, residential factors, and employment shape the life course timing of when low-income adults enter healthcare safety net organizations. This examination builds on and

extends prior theoretical work on safety net usage as a life course “event” (following Rank and Hirschl 2002; Irving 2008) by assessing the timing of healthcare safety net entrance in the context of longer-term health trajectories. This investigation enabled the identification of organizational features that shaped the ways low-income and uninsured adults entered into CHC and related to wider processes of cumulative health disadvantage (Dannefer 2003; DiPrete and Eirich 2006).

Chapter 3 concerns identifying how workers’ expressions of individual agency relate to organizational efforts to mitigate the reproduction of inequality. Guided by symbolic interaction theory (Blumer 1955; Goffman 1967; Rock 2001), I examine culturally and situationally nuanced features of healthcare workers’ cognitions about their workplace roles and the scope of their everyday efforts to reduce patient health inequalities. I analyze how these processes unfold in a particular organizational contexts by integrating and applying insights from extant work on street-level bureaucrats (Watkins-Hayes 2009; Lipsky 2010), organizational logics and complex organizations (Thornton et al. 2012; Perrow 1986; Hasenfeld 2010); the performance of race and gender in workplace settings (following West and Zimmerman 1987; Jackson 2001; Warren 2001; Markus and Moya 2010; Wingfield 2009, 2013), and the reconfiguration of race relations in NIDs (following Bonilla-Silva 2004; Marrow 2009, 2011). I assess how organizational logics at CHC in turn relate to workplace strategies undertaken to reduce disparities in everyday worker-patient interactions in the context of workers’ understandings of

diversity in the workplace, knowledge of current clinical “best practices,” and attitudes about the reproduction of inequality in the context of a NID. This chapter presents a conceptual model relating worker characteristics, decoupling behaviors of “racial/ethnic resistance” undertaken in efforts to provide more equitable healthcare treatment, organizational change, patient-level characteristics, and patients’ long-term health trajectories.

Chapter 4 concerns clarifying the role of healthcare safety-net organizations in shaping the attitudes, feelings, and expectations that low-income adults have about their health, everyday hardships, the kinds of resources available to them, and their hopes for the future. Again guided by symbolic interaction theory, and building on the recent work of Kangovi et al. (2013), I move beyond studies of general attitudes and standard analyses about low-income and racial/ethnic minority adults’ expectations concerning the trustworthiness of healthcare providers (for a review see Shavers et al. 2012; Gupta et al. 2014; Armstrong 2007) to examine how culturally and situationally nuanced features of low-income and uninsured unauthorized Latina immigrants’ cognitions develop over time and in direct relation to the interactions they experience with healthcare safety net workers. This effort further develops theoretical insights regarding the role of safety-net organizations as “framing institutions” that shape the narratives, coping strategies, and variation in likelihood of adults and their families thriving following a significant illness diagnosis or other life course event (Watkins-Hayes,

Pittman-Gay, and Beaman 2012; Clark, Glick, and Bures 2009; Harding, Dobson, Wyse, and Morenoff 2016).

## **2. Becoming a Patient at a Private Primary Care Safety-Net Clinic**

### **2.1 Abstract**

What role does transitioning into the status of “patient” at a healthcare safety net organization play in the cumulative health disadvantage experiences of uninsured Americans? Guided by insights from research on life course transitions, cumulative health disadvantage, and safety-net organizations, this study explores how organizational processes shape the pathways through which uninsured adults become patients in a private primary care safety net clinic and relate to their healthcare seeking behaviors. Data include fieldnotes from an ethnography of a private healthcare safety net clinic conducted from 2011-2016 and audio-recorded interviews with a purposive sample of 51 workers in this setting and 97 uninsured adult Black, Latino, and White female and male patients ranging from 22 to 86 years old. Findings suggest that features of distinct entrance pathways may alternately exacerbate or mitigate processes of cumulative health disadvantage by stratifying the socialization of patients into accessing different types of healthcare treatment. Policy implications and directions for future research are provided.

Key Words: healthcare seeking, healthcare safety net, life course transitions, cumulative health disadvantage, healthcare disparities

## **2.2 Introduction**

What role does transitioning into the status of “patient” at a healthcare safety net organization play in the cumulative health disadvantage experiences of uninsured Americans? Most recent empirical research on the social safety net has been centered on understanding the consequences of welfare reforms. Scholars in recent years have argued that successive transformations of safety-net welfare resource provision in the contemporary neoliberal era have been crafted by state actors to observe and punish (Wacquant 2009) or, alternately, to transform the poor into increasingly morally-deserving agents through disciplinary mechanisms grounded in market principles (Soss, Fording, and Schram 2011). Researchers have documented the fragmentation of material resource provision across an increasing number and type of organizational domains (Hacker 2002, 2004), and some have explored how a growing proportion of welfare resources have been provided to poor families through private organizations (Morgan and Campbell 2011). Others have sought to investigate the consequences of welfare reforms by centering their analyses on the experiences of poor families (e.g., Moffitt, Cherlin, Burton, King, and Roff 2002).

Unfortunately, however, research on the healthcare experiences of poor Americans has progressed at a slower rate in recent years. No doubt, a wide and growing body of empirical research has explored the provision of healthcare through public programs and organizations. The most notable streams of research in this area



have centered on investigating integrated services for Medicaid-eligible individuals diagnosed with HIV (Watkins-Hayes, Pittman-Gay, and Beaman 2012; Watkins-Hayes 2014) and the reproduction of racial inequalities among pregnant women in public safety-net hospitals (Bridges 2011), and recent work on Federally Qualified Health Centers (e.g., Richards, Saloner, Kenney, Rhodes, and Polsky 2014). Scholars in recent years have pointed out that we know relatively little in this point in time about the role of private nonprofits in the healthcare safety net (Almgren and Lindhorst 2012).

It is critical to close this knowledge gap, especially in the contemporary period in the years following the passage of the Affordable Care Act (ACA). The ACA, a far-reaching set of healthcare reforms signed into law in 2010, includes provisions designed to improve the quality and affordability of health insurance and expand insurance coverage to a larger proportion of Americans. Under its original provisions, expanding insurance coverage was to be achieved in part via expanding access to Medicaid, a form of public insurance for low-income families. However, 19 states did not elect to expand Medicaid coverage (Frean, Gruber, and Sommers 2017).

The present study seeks to advance the state of social scientific knowledge of how private nonprofit healthcare safety net organizations relate to the healthcare experiences of low-income and uninsured adults residing in a mid-sized urban context in the southeastern U.S. in which Medicaid eligibility was not expanded in the years following the passage of the ACA. Focusing on the experiences of individuals

interacting in one safety-net primary care clinic, this investigation contributes to a wider body of research on interactions within particular social settings as a mechanism in the reproduction of inequality, aiming “to understand the interactive processes through which inequalities are created and reproduced in concrete settings” (Schwalbe, Godwin, Holden, Schrock, Thompson, and Wolkomir 2000). This examination builds on and extends prior theoretical work on safety net usage as a life course “event” (see Rank and Hirschl 2002; Irving 2008) by assessing the timing of healthcare safety net entrance in the context of longer-term health trajectories experienced by low-income and uninsured adults.

## ***2.3 Theoretical Background***

### **2.3.1 Class Heterogeneity among Low-Income Uninsured Adults**

While conventional wisdom posits that safety net resources tend to be used by families living in poverty for long periods of time, Rank and Hirschl (2002) find that two thirds of Americans between the ages of 20 and 65 will at some point in their lives live in a household that receives welfare benefits. A wide body of research on race/ethnicity and class stratification suggests that the population of low-income adults in the United States at any given time is composed of a mixture of two broad groups: (1) individuals with relatively lower levels of educational attainment who reside in relatively poorer households, experience more precarious work conditions and poverty for long periods of time, and are disproportionately members of racial and ethnic minority groups, and

(2) individuals with relatively higher levels of educational attainment who reside in relatively wealthier households, generally experience less precarious work conditions and shorter-term unemployment spells, and tend to be white (Oliver and Shapiro 2006; Bonilla-Silva 2001; Omi and Winant 2014; Kalleberg 2009). Since health insurance coverage of adults ages 18-64 in the U.S. is closely linked to current employment conditions, considerable class heterogeneity is likely to exist within the population of low-income and uninsured adults who use healthcare safety net resources.

A wide body of research documents far-reaching effects of social class stratification. Bourdieu (1990) theorizes that social class status shapes an individual's habitus, or set of cognitive structures orienting oneself toward the world and shaping strategies of action undertaken in everyday life. Recent empirical research supports the notion that class habitus is fixed relatively early in life and is resistant to change (Streib 2011, 2015). Life course scholars have extensively investigated the "long arm" of social conditions experienced during critical periods earlier in the life course on health and mobility outcomes decades later (Elder and Rockwell 1979; Elder 1994; Hayward and Gorman 2004; O'Rand and Hamil-Luker 2005). For example, Pearlin and colleagues theorize that long-term economic strain and discriminatory experiences are sources of stress that powerfully contribute to worse health, and stress proliferation unfolds as individuals who are exposed to one serious adversity are placed at higher risk for later exposure to hardships (Pearlin, Schieman, Fazio, and Meersman 2005).

Some have also explored how socialization processes in the context of coping with series of adverse life course events can alter individuals' ways of making sense and finding meaning in the world. Watkins-Hayes, Pittman-Gay, and Beaman (2012), for example, report that low-income women diagnosed with HIV/AIDS experienced marked transformations in their understandings of their illnesses and expectations for the future by developing enhanced coping strategies, in part through their exposure to institutional contexts which facilitate the development of cognitive frames for altered understandings.

Educational attainment and wealth are considered to be more accurate measures of an individual's ability to access some health-protective resources than current income level (Diemer, Mistry, Wadsworth, Lopez, and Reimers 2012; Coleman 1988; Pfeffer and Hertel 2015). While higher-SES households may access safety net healthcare treatment during unemployment spells, they experience shorter-term periods of less acute social and economic uncertainty than those living in poverty for extended periods of time. Higher-SES individuals who experience gaps in insurance coverage due to unemployment spells may have additional resources to fall back on due to their higher levels of educational attainment and wealth than those living in the more chronically uncertain conditions of long-term poverty. At the same time, downward mobility signifies a break with an anticipated sequence of life course events, and the subjective experience of status loss is frequently an acute stressor which may lead to others

(Pearlin, Schieman, Fazio, and Meersman 2005). Some have sought to understand coping strategies in the face of these more temporary uncertain conditions, for example by investigating how adaptations in self-concept among high-status workers who seek to make sense of unemployment spells and find meaning through their participation in peer support groups (Garrett-Peters 2009).

Chronic uncertainty, or the long-term exposure to multifaceted adverse social and economic conditions constituting highly resource-constrained environments, typify the lives of individuals living in poverty for extended periods of time (Garrett-Peters and Burton 2015; Burton and Tucker 2009; Edin and Lein 1997; Silva 2013). Living in chronically uncertain conditions may shape the cognitions and behaviors of relatively disadvantaged utilizers of safety net organizations such that their concern with day-to-day survival and a lack of predictable resources shapes a “hesitancy to act, and a diminished likelihood of acting in ways more likely to create better outcomes for individuals and their families” (Garrett-Peters and Burton 2015:246). Social class heterogeneity may contribute to the reproduction of inequality among patients in safety net healthcare settings, as poorer individuals may apply strategies aimed to mitigate chronic uncertainty in the short term, while higher-SES individuals may engage in more effective strategies for securing healthcare treatment.

Taken together, the extant scholarship reviewed above indicates that class heterogeneity among low-income adults as they encounter chronic and temporary

uncertainty is important to consider as a possible contributor to the reproduction of inequality. Individual-level cognitive and behavioral factors set in place before the time of entrance into the healthcare safety net may shape strategies for interacting with the healthcare safety net. However, as some studies discussed above (e.g., Watkins-Hayes, Pittman-Gay, and Beaman 2012; Garrett-Peters 2009) document, interactions with institutional environments also contribute to the reproduction of inequality. Below, I explore how safety net healthcare service provision may also function either to mitigate or to exacerbate cumulative health disadvantage processes.

### **2.3.2 The Role of Safety Net Organizations in Cumulative Health Disadvantage**

Research on cumulative health disadvantage and life course transitions provides a useful set of conceptual tools to examine how safety-net organizations may structure longer-term trajectories of health and mobility for socially and economically disadvantaged populations. The central claim of cumulative disadvantage theory is that a favorable relative position generates gains across the life course, resulting in the growth of the advantage of one individual or group relative to another across time. This perspective further posits that the various trajectories that are evident later in life originate from early inequalities. Individuals who begin in a position of advantage maintain this relative standing and even experience increased gains as they age. On the other hand, those who are subject to disadvantage in childhood face the opposite phenomenon, with a further accumulation of risk factors that amplify their

disadvantaged status over time. It is therefore reasonable to expect that early disadvantage (e.g., confusion or misinformation about how to most effectively engage in healthcare-seeking behavior at the onset of entering into a healthcare safety net organization) can generate a chain of events that increase the likelihood of a patient experiencing poor healthcare safety net encounter outcomes over time.

Watkins-Hayes, Pittman-Gay, and Beaman (2012) find that for some disadvantaged women, receiving an HIV/AIDS diagnosis leads to them becoming eligible to receive goods and services they were otherwise unable to access. As these women encounter a more integrated set of safety net resource provision in the context of a significant illness diagnosis, they are able to access new sets of material goods and healthcare services. A paradoxical and highly significant transition in the life course experiences of these women occurs as they receive access to a wider variety of goods and services than before they received a significant illness diagnosis. Over time, as they utilize these resources and engage in conversations with supportive bureaucrats, these women experience a “framing institution” that alters not only short-term access to material goods and services but also psychological outcomes including sense of self-efficacy, self-esteem, coping skills, and mental health. Exposure to safety-net organizations over time, then, may positively alter long-term life course health and mobility trajectories.

It is also important to consider the ways that inequality may be reproduced and potentially exacerbated through the human service organizations which together constitute the healthcare safety net. Garrow and Hasenfeld theorize that Bourdieu and Wacquant (1992) may be drawn on to view “the organization...as a contested relational and stratified field in which different actors compete and struggle for access to valued resources by using their economic, social, and cultural capital” (2010:49). For Garrow and Hasenfeld, classification and categorization schemas articulated in organizational policies surrounding “how service goals and objectives are expressed, how clients are defined, and how workers rationalize their work” are produced by contentious interactions between actors with differential access to power (2010:49). Hasenfeld (2010) theorizes that human service organizations are settings uniquely characterized by the importance of client-worker relations, emotional labor, and the gendered bureaucratization of human care. Hasenfeld and others (e.g., Acker 1990) have argued that organizations are not structured in gender-neutral ways but instead “the positing of gender-neutral and disembodied organizational structures and work relations is part of the larger strategy of control” (Acker 1990:139).

Although organizational theorists tend to treat bureaucratic processes as race-neutral, scholars of racial inequality have recently proposed theories positing that racial inequality is reproduced precisely through these meso-level bureaucratic mechanisms. Informed by Acker’s (1990) theoretical explication of the ways formal organizations are



gendered in their operation and consequences, Ray (2017) posits that formal organizations are also patterned by a logics of racialization, such that even amid their ostensibly race-neutral and objective systems of rewards and sanctions, they may tend to confer rewards on superordinate racial groups while punishing subordinate groups. Safety net healthcare organizations may contribute to the reproduction of inequality if they function in ways that heap rewards on relatively advantaged groups while levying punitive sanctions on members of relatively disadvantaged groups. Over time, this process may exacerbate cumulative health differences between groups as individual patients are repeatedly exposed to differential levels of healthcare treatment quality and health-promoting safety net resources.

## ***2.4 Data and Methods***

### **2.4.1 Overview of the study**

To investigate patients' experiences entering safety-net primary care resources in relation to their efforts to traverse life course processes of accumulating health disadvantage, I analyzed qualitative data on uninsured adult patients at Compassion Health Clinic who participated in a team-based ethnographic study conducted by the author. This research project was a longitudinal, multimethod project designed to examine how the everyday experiences of low-income and uninsured adults shape both the healthcare and welfare resources they have access to and the ways in which they navigate private safety-net healthcare organizations in the years following the passage

of the Affordable Care Act. Study participants resided in a mid-sized city in the southeastern U.S. which has become a New Immigrant Destination. Primary data collected in this study included longitudinal ethnographic observations and informal interviews of healthcare safety-net workers, patients, and their families. Audio-recorded in-depth interviews with a purposive sample of workers and Black, Latino, and non-Hispanic White female and male uninsured patients were conducted to better understand heterogeneity in life course experiences and cognitive approaches toward the role of a private healthcare safety net setting in patients' everyday lives.

#### **2.4.2 Field site**

Mueller conducted a longitudinal organizational ethnography of Compassion Health Clinic (CHC) from 2011-2016. CHC is a private primary care clinic in an urban safety net located within the southeastern U.S. Opening its doors in the early 2000s, CHC's founders saw themselves as emulating the model of safety-net healthcare provision provided by Church Health Center in Memphis, Tennessee. They sought to draw financial and volunteer support from congregations, individual donors, foundations, and other local healthcare entities to provide affordable primary care for local uninsured community residents who were employed in low-wage jobs and fell in the health coverage "gap" between Medicaid and private insurance.

During its first few years, CHC's patient population was composed of approximately 45% Black, 10% Latino, and 45% White patients. Although women have

consistently comprised approximately 70% of its patients, CHC experienced a distinct shift in the racial/ethnic and class composition of its patient population over time. The rate of new patients who were Black or White remained relatively steady, but increasing numbers of Latinos sought to receive primary care at CHC in the years since its founding. By 2010, the patient population had become approximately equal thirds Black, Latino, and White.

With the passage and partial implementation of the Affordable Care Act, patients with relatively higher incomes accessed coverage through the Health Insurance Marketplace and subsequently left CHC. In 2012, and for the first time in years, CHC no longer had a waiting list. In fact, it had fewer patients than it was capable to treat as an organization. As CHC opened its doors to new waves of patients seeking primary care, it found that these new patients brought increasingly complex health needs, a wider array of languages spoken, more acute social stressors, and higher levels of financial hardships.

In 2015, approximately 79% of CHC patients had one or more chronic health conditions (diabetes mellitus, COPD, and hypertension were the most common), and 58% of patients had comorbid chronic health conditions. These new waves of patients were more costly to CHC, as their lower income levels meant patient co-pays tended to cover a lower proportion of the clinic's average \$95 cost for a healthcare encounter (co-pays were assigned on a sliding scale according to income, and are described in more

detail in the Findings section below). Organizational leaders took the larger number of languages spoken, more acute social stressors, and more challenging financial hardships among CHC's patient population over time to warrant a wider array of language resources and more systematic coordination with other safety-net organizations in efforts to address patients' unmet non-medical needs.

CHC leaders entered into formal arrangements to partner with other local organizations that served uninsured community members, which led to the emergence of two additional pathways for uninsured community members to become patients at CHC. Beyond entrance via the front door, some patients began to arrive at CHC via direct referrals from City Hospital (a large trauma center located nearby), and others began to arrive via coordinated referrals through other local safety-net organizations.

### **2.4.3 Recruitment and sample description**

After gaining entrée at CHC, Mueller asked 31 paid and 48 volunteer workers to participate in informal ethnographic interviews via face-to-face recruitment conversations. 78 of these 79 workers consented to participate in informal interviews, with one physician volunteer expressing that he was interested in sharing his perspective but did not have time; this worker stopped volunteering at CHC and moved cities shortly after the time of this recruitment attempt, which occurred in 2012.

Longitudinal participant-observation and informal ethnographic interviews allowed the identification of key insights and additional questions for further

exploration in in-depth interviews. A purposive sub-sample of 51 workers was drawn, and included volunteers, support staff, welfare workers, medical providers, and high-level administrators. Each of these 51 individuals were asked to participate in an audio-recorded semi-structured in-depth interview, and each consented to do so. Follow-up interviews were conducted with five respondents, producing a total of 56 audio-recorded interviews with this sub-sample.

Patient interview respondents were recruited into the study and interviewed between May and July 2016. Recruitment of patients occurred through face-to-face interactions between ethnographers and potential respondents in the waiting room at CHC. A total of 128 patients were asked to participate in audio-recorded semi-structured in-depth interviews lasting approximately 60 minutes. 12 patients expressed that they were uninterested and did not participate in the study, 19 shared that they did not have time for a long interview but shared their perspectives in informal conversations, and 97 consented to participate in an in-depth interview. Table 1 provides the number of in-depth interview respondents, informal interview respondents, and patients who declined to participate in the study by race/ethnicity and gender.

**Table 1: Patient Interview Respondents**

Patient group	In-depth interview respondents	Informal interview respondents	Patients who declined to participate
Black women	24	2	0
Black men	16	1	2
Latina women	21	6	4
Latino men	14	7	5
White women	13	1	0
White men	9	0	1

At the time of enrollment in the study, all 116 patients who participated in this study reported household incomes below 125 percent of the 2016 federal poverty guideline; were not covered by Medicaid, Medicare, or private insurance; and ranged in age from 22 to 86 years old. 108 respondents had been diagnosed with multiple co-occurring chronic physical illnesses (most commonly diabetes mellitus, hypertension, and conditions under the umbrella of chronic obstructive pulmonary disease [COPD]). 37 respondents had become patients at CHC within the past six months, 45 had been patients at CHC for between six months and two years, and 34 had been patients at CHC for more than two years.

#### **2.4.4 Data sources, coding, and analysis**

Data sources include longitudinal ethnographic field notes, informal ethnographic interviews with 78 workers documented in field notes, 56 audio-recorded in-depth interviews with 51 workers (47 workers were each interviewed once, 3 were

interviewed twice, and one worker was interviewed three times times), 19 informal interviews with patients documented in field notes, and 103 audio-recorded in-depth interviews with 97 patients (six new patients were re-interviewed a few months after the time of their first appointment).

Field notes documented discussions and the implementation of policies governing patient eligibility criteria and organizational processes facilitating new patients' treatment at CHC in everyday workplace interactions; informal interactions among workers and volunteers during lunch breaks, holiday parties, and staff birthday and retirement parties; board meetings; and fundraisers. Interviews with a purposive sub-sample of 51 workers was drawn to further explore understandings of CHC's policies, work environment, and relationship to long-term patient health. An interview guide is included in Appendix A.

From May-August 2016, a team of ethnographers led by Mueller conducted audio-recorded in-depth interviews with 97 patients. A sample interview guide is included in Appendix B. Interviews with respondents were audio-recorded, transcribed, and translated into English if necessary (38 interviews were conducted in Spanish). Second, informal ethnographic interviews with an additional 19 respondents also contained sufficient data for inclusion in this study. Interviews and ethnographic field notes were coded collaboratively in team data analysis (TDA) sessions. TDA sessions involved ethnographers' (1) identifying and interpreting salient themes that emerged in

each interview case and clinic day before subsequently (2) identifying connections, similarities, and differences across cases and (3) finding group-level patterns.

## **2.5 Findings**

This collaborative coding process led to the identification of salient factors linked to three distinct entrance pathways through which uninsured adults became CHC patients. Before their first appointment at CHC, new patients gained access to healthcare treatment in this setting by either (1) waiting in line at the front door to submit a completed patient application packet (89 respondents), (2) receiving an assigned appointment at CHC as a component of their discharge from City Hospital (15 respondents), or (3) receiving a referral from a caseworker at another local safety net organization (12 respondents). Each entrance pathway was accompanied by a distinct set of eligibility criteria, organizational resources, and subset of workers who facilitated community members' transition into "patient" status. Patients at CHC were not evenly distributed across entrance pathways, and a stratification pattern emerged across entrance pathways according to language ability and class status. The "front door" had the highest proportion of non-English-speaking patients, the "side door" had patients that experienced food insecurity, and patients who entered via the "back door" tended to be white and have higher class statuses.

Findings are organized below to describe the observed pathways through which uninsured adults gained the status of "patient" at CHC. Exemplar cases from the patient



interview sample are described to illustrate connections between entrance pathways and patients' socialization experiences into CHC in the context of their everyday experiences with poverty and uncertainty. These cases also provide insights regarding possible long-term impacts of entrance pathways on health treatment trajectories and cumulative health disadvantage processes.

### **2.5.1 The Front Door: Playing by the Rules of the Safety Net**

Approximately 77% of respondents entered CHC via informal, word-of-mouth referrals. Informal referrals led uninsured community members to seek out CHC, regardless of their eligibility. Rosario, a Patient Services worker who spent a majority of her time interacting with prospective patients at the front desk, shared that she would like to be able to admit everyone who walks in the door to an appointment with a healthcare provider. Unfortunately, even though she could see on the appointment calendar that there were appointments available, CHC's eligibility policies restricted the ability of prospective patients to access treatment. She shared with me, "It's like, they've overcome a lot just to get here in the first place, so why [do we have to] turn them away?" When I asked her what kind of unnecessary restrictions CHC placed on prospective patients, she shared that everyone who is a patient at CHC is supposed to

have someone in their household who is employed, must be at least 18 years old, and cannot be pregnant.<sup>1</sup>

To become patients via informal referrals, eligible community members were subject to CHC's formal organizational policies stipulating that all new patients were to be seen in an appointment with a healthcare provider only after three steps were met. First, employees in the organization's Patient Services department reviewed and approved the prospective patient's completed "patient application packet." This packet included tax records, proof of employment, and proof of residency in the county surrounding CHC. Together, these documents were the means through which workers at CHC assessed whether prospective patients fit into its target population of "working uninsured" adults in the local community. Second, after initial review of the patient application packet was completed and the prospective patient was deemed eligible for CHC's services, they were assigned a "co-payment" fee to be assessed at each appointment. Third, patients were assigned an appointment date, informed of the amount of their co-payment fee, and were required to pay this fee before their appointment. Patient co-payment fees ranged from \$25-\$95 and were assigned according

---

<sup>1</sup> These eligibility criteria were originally put in place when CHC first opened its doors in the early 2000s. Administrative leaders recounted to me that at the time, they understood CHC's role in the community as serving the "working uninsured," whom they saw as the group who earns too much money to qualify for Medicaid but not enough to be able to afford private insurance or employer-based coverage. Leaders decided to focus their practice on providing primary care services to uninsured adults, and saw both pediatric and prenatal care as outside the scope of what was feasible for them to accomplish. In Rosario's view, however, these eligibility criteria posed a set of restrictions that forced her hand as she routinely denied community members who were unemployed, under 18, or pregnant from becoming patients able to access CHC's healthcare team.

to a sliding scale based on patients' annual household income as reported in the patient's income tax return from the prior year.

Only new patients who entered CHC via informal word-of-mouth referrals experienced this three-step procedure before they accessed their first appointment. New patients who were formally referred to CHC by either a local Emergency Department or another safety-net organization experienced different procedures as they became CHC patients, which are described below.

Those who entered through the front door tended to see this setting as one among others in a healthcare system to which they experienced widely varying levels of access over time. For example, Jennifer, an African American woman in her 50s, shared that she is not eligible for primary care through Medicaid and cannot not afford health insurance coverage, so she tends not to have regular check-ups, but to instead seek out healthcare only when she feels sick.

Over the past 13 years, Jennifer experienced a sequence of changes in her health insurance coverage and eligibility to receive healthcare treatment at different primary care clinics in the community. In 2004, she did not have health insurance and described having a bad experience at another safety net clinic. She decided not to go back to this setting, and shared that for the next three years, she did not have any other encounters with healthcare clinics. In 2007, her brother-in-law sought out CHC when he became sick, and shared with her that he had a favorable set of experiences with this

organization. She came to CHC because of his referral, found this setting a friendlier environment than others where she had previously received treatment, described her relationship with her doctor at CHC in favorable terms, and recommended to her cousin that he also come to CHC.

Jennifer's doctor diagnosed her with high blood pressure shortly after her first visit to CHC in 2007, and she received care at this setting for a few years. Jennifer shared that in 2012, she stopped going to CHC and instead signed up for health insurance coverage through the Affordable Healthcare Act's health insurance marketplace. She found a private practice that accepted her coverage plan and began receiving treatment there. However, she quickly found that she could not afford the premiums, so she cancelled her coverage. She then sought to enroll in Medicaid, but found herself only eligible for family planning coverage, which she found unnecessary as she was now in her 50s and post-menopausal. Jennifer did not come back to CHC at this point, and stopped taking her prescriptions when she ran out of refills. She shared that she was then taken to the hospital in the spring of 2016 by her sister, and was hospitalized for four days. She received a \$25,000 bill for this stint, and was referred to a lung specialist for a follow-up appointment. However, when the specialist's office learned about her lack of insurance coverage upon her arrival at her follow-up appointment, she was informed that she would not be able to receive treatment. Frustrated, she turned again to CHC in the summer of 2016, where she trusted her doctor from years before. "I didn't

have no problems getting back," Jennifer shared, "I just knew I had to do paperwork." Now, she shares, "[CHC is] trying to get me some help, like the charity care... so they can help that [\$25,000 hospital] bill." She continues:

I have to have a lung doctor, so [my doctor at CHC] gave me the paperwork to fill out and send to [a nearby city] for charity care with them...so yeah, she try to help you, you know, get that avenues that will help...she diagnosed my high blood pressure in 2007... so she knew my history, that's why I wanted to come back to her, cause I knew she had been dealing with, you know, my stuff.

For Jennifer and others who became patients via the front door, CHC's paperwork felt like other safety-net bureaucracies with which they had interacted. Paperwork was a hurdle to overcome, but once they did, they expressed varying degrees of trust with their medical provider.

For patients like Jennifer, receiving treatment from the same healthcare provider even though a few years had passed was associated with healthcare system trust. However, Jennifer and others who entered via the front door shared that they sometimes limited the frequency of their appointments at CHC due to their inability to afford the clinic's co-payment fees. Although co-payments helped the clinic to defray the cost of an appointment with a healthcare provider (which averaged \$95), they were explained by one of CHC's

senior administrative staff as “primarily symbolic...we’re not a free clinic because we want [CHC] patients to invest in their health and take ownership of their life instead of just, you know, coming here for a handout.”

Six respondents who entered via the front door reported paying \$35 for their assigned co-payment, while the rest reported paying \$25. Five of the six respondents who were charged \$35 per visit and 52 of the 83 respondents who paid \$25 (approximately 63%) expressed dissatisfaction at CHC’s fee structure. These individuals shared that they struggled to pay their assigned co-payment fees, and among patients in this group, four themes emerged as sources of dissatisfaction around CHC’s sliding-scale method of assigning co-payment fees at a minimum level of \$25 and based on their previous year’s tax records. Respondents shared that they felt this did not take into account (1) more recent changes in their income status, (2) whether they had access to this income directly or if was controlled by someone else in their household, (3) the number of individuals living in the household, or (4) the possibility that they may not be able to afford even the lowest co-payment level of \$25 per visit.<sup>2</sup>

---

<sup>2</sup> Patients who accessed CHC’s “back door” through ED referrals or “side door” via safety-net referrals did not express dissatisfaction at CHC’s fee structure or concerns about their ability to pay. This could be the result of new patients who entered CHC via “back door” and “side door” channels incurring no cost for their first one (in the case of some ED referral cases) or two (in the case of all safety-net referral cases) appointments and the automatic assignment of \$25 co-payment fees (the lowest available level) for subsequent appointments.

## **2.5.2 The Back Door: Skipping the Line via Emergency Department Referrals**

Approximately 13% of respondents (15 of 116) reported having entered CHC's appointment schedule directly via Emergency Department (ED) referral appointments. These referrals were not scheduled by CHC staff, but by workers at City Hospital, a nearby trauma center. Patients observed to enter CHC through this pathway included two Black women, four Black men, two Latino men, one White woman, and six White men. This "back door" into the appointment schedule, as it was sometimes referred by CHC workers, was the result of a partnership that enabled City Hospital to refer patients with no reported usual source of care to CHC. This entrance trajectory emerged through the efforts of City Hospital administrators to reduce the amount of non-emergent Emergency Department (ED) usage. They saw non-emergent ED usage by uninsured community members as a driver of uncompensated hospital spending, and administrators and the community health team at this hospital had long been interested in encouraging what they referred to as "high utilizers" of the ED with non-emergent needs to become established patients at local safety-net clinics.

CHC was financially incentivized to partner with this hospital for two reasons. First, the partnership promised to pay a certain proportion of its operating budget (and thus provided a relatively reliable source of income to go alongside income from individual and corporate donations, patient co-pays, and other in-kind gifts). Second, the partnership promised access to new streams of technical support resources for CHC,

including an enhanced computer system with rolling carts enabling conference calls with medical interpreters for CHC's growing non-English-speaking patient population and access to this hospital's Electronic Medical Records (EMR) software system, which was more reliable, less prone to crashing than CHC's current system, and allowed EMRs to be shared across clinics.

Back door ED referral patients met with community health nurses from City Hospital. These nurses provided assistance in completing patient application packets and sought to understand whether patients had any social hardships that may be barriers to their health or to establishing CHC as a usual source of care (such as food insecurity, medical systems distrust, financial hardship in paying appointment co-pays or for prescriptions, and transportation issues). Community health nurses sought to address these issues through a variety of strategies unavailable to other patients. Observed strategies included helping patients find local food pantries and providing transportation to apply for food stamps and welfare assistance. City Hospital community health nurses also provided their new patients with counseling and encouragement, in the words of one nurse, to "give [CHC] a chance...because the front desk people are nicer here and really care about the patients and the lines aren't as long [as they are at other safety net clinics]." If the new patient expressed that they were experiencing financial hardships, the community health nurse offered to pay their co-pay out of pocket, to later be reimbursed by City Hospital's petty cash funds.



A CHC worker shared that about half of the patients who entered via the “back door” not because of their non-emergent usage of the ED, but as a means to receive follow-up treatment following an acute health event. For example, a 63-year-old white man was also first referred to CHC after his chronic heart problems led to a heart attack and heart surgery. He now sees a volunteer cardiologist at CHC periodically and receives free medication. Michael, another white man, was laid off from his job as a mechanical engineer and experienced a heart attack approximately five months after he lost his job, and after he lost the health insurance coverage provided by his employer. He was referred to CHC for follow-up care. Both of these men expressed their gratitude at the presence of the City Hospital community health nurse when they first became patients in the summer of 2016. Michael was interviewed before his first appointment at CHC and again shortly after his second appointment, a few weeks later. Each time I interacted with Michael, I noticed that he carried a small notebook in which he took notes during informal conversations, and asked probing questions about the availability of additional resources beyond what seems immediately present at CHC. Michael’s approach toward CHC’s resources contrasts with the observed behaviors of other respondents who live in more chronically-uncertain conditions.

Poorer individuals also interacted with City Hospital’s nurses before their first CHC appointments. Although they also entered via the back door, they were slower to warm to the community health nurse. Jackie shared that she felt the nurse asked

intrusive questions that did not seem relevant to the immediate reasons for her healthcare appointment scheduled for that day. Over the course of their conversation, however, she increasingly opened up to the nurse and began asking questions about other sorts of resources that may complement their efforts to live a healthier life. After their conversation was finished, I noticed that Jackie continued asking the same sorts of questions to her healthcare provider. Before she left, Jackie asked the staff person at the front desk if she knew of any other safety-net resources to which she might be referred.

Overall, those who entered into CHC via this channel viewed the clinic as a connection to specialty medical resources and targeted non-medical resources to address their unmet needs. However, uninsured adults who were referred through this pathway did not have equal levels of success in accessing community health nurses to ease their entrance into CHC. The community health nurses did not speak Spanish, so there were no Spanish-language ED referral services available. Spanish-speaking patients who were new referrals from City Hospital did not access the resources provided by community health nurses, since they entered CHC when no bilingual community health nurse was present. An 89-year-old unauthorized Latino immigrant, for example, first accessed CHC via a referral through City Hospital. He shared in an interview that gaining access to this clinic's medical services helped address some unmet needs in his life, but he still feels that he could benefit from mental health care, increased knowledge of where to access healthcare for his family, and resources to address his food insecurity. He is not

aware of other resources that may be accessed through CHC or in the wider community, although this knowledge would have presumably been provided to him by the community health nurse if they were able to communicate as he became a CHC patient.

### **2.5.3 The Side Door: Safety-Net Handoffs and Relaxed Eligibility Restrictions**

Approximately 10% of patient respondents (12 of 116) entered CHM via formal referrals from other safety-net organizations. Patients who entered via side door safety-net referrals secured access through a case manager at another safety-net organization, which allowed them to have two free visits and a waived employment eligibility requirement.

A foundation had recently awarded CHC and a group of other private safety-net organizations a grant to spur new forms of collaboration and resource-sharing across organizations. A portion of this grant paid for Ms. Denise's salary as a caseworker housed at another organization whose role entailed connecting clients from one organization to others in order to address their unmet health needs and provide resources to lessen the severity of financial hardships and food insecurity. If Ms. Denise referred a new patient from another safety-net organization to CHC, the patient could expect to receive periodic phone calls from Ms. Denise offering bus passes, gas cards, social support, and recruitment for job training/placement programs.

Notably, patients could also expect relaxed eligibility requirements and lower fees if they entered CHC through Ms. Denise's referral. A stipulation of the collaboration

was that CHC was to waive its employment eligibility requirement and first two visits for newly referred patients. The visits, free for patients, were subsidized by the grant encouraging this organizational collaboration, and the waived employment eligibility requirement was justified by CHC leaders because new patients referred via this arrangement were also in the process of being referred to nonprofits providing job training and placement services. These new patients, although currently unemployed, were seen as actively taking steps to gain employment and therefore counted as part of CHC's target patient population of "working" uninsured adults.

One morning, as I sat in the waiting room at CHM observing a long line of patients waiting to speak with a worker at the front desk window, I noticed a middle-aged Black man take a step away from the window, hang his head, and say, "Well, ok, thank you for your time, but I thought Ms. Denise said I did not have to have a job right now to be seen by a doctor here." Maria, the worker staffing the front desk at the time, looked up, her demeanor instantly changing from a kind of muted disappointment at her job of turning prospective patients away to a newfound sense of freedom. She responded enthusiastically, "Oh, you should have told me that you met with Ms. Denise! Yeah, you don't have to have a job, and you don't have to pay today either because you were referred to us by them."

Sherry, an African American woman who was also a new patient referred by Ms. Denise, shared that she was surprised at CHC's efficiency during her intake process:

Well this is my first time being here and it feels good to be a patient here. It's real considerate and nice and... normally when you're not paying any money, it's like paperwork, paperwork, paperwork. I don't think I wrote down or put my name on anything...it's my first day, yes, [and I was] expecting [to do] a lot of paperwork then, but I came right on in. Boom, Bam! They got my little slip that I did my paperwork [that] I did to get here, and I went on upstairs in five minutes....[The paperwork that I did before] just tells what you're allergic to, are you on any type of medication, and when the last time you had a physical, you know the basics. Your age and all of that, you know family history.

Sherry describes the relative ease through which she gained access to CHC's services. Relative to those who became CHC patients via its front door or ED referrals, Sherry and others who entered CHC via this entrance pathway were afforded a more relaxed set of eligibility criteria, and were not required to provide supporting financial or employment documentation.

Each of the twelve respondents who entered CHC via this pathway viewed the clinic as one organization embedded in a broader, tight-knit network of collaborating organizations. Four of these patients were re-interviewed a few months after their first appointments. Each shared that they were more proactive about their health due to their ability to access CHC and other health-promoting safety-net resources. Mary, for

example, shared in her second interview that she draws strength from her periodic check-ins with Ms. Denise. She shared that she is now eating a daily salad and smaller overall portions, and now regularly walks three miles each day.

Mary is still regularly taking her high blood pressure prescriptions and attending her appointments, but shared that she sometimes asks Ms. Denise for medical advice rather than CHC workers because she is easier to access. In a subsequent interview with Ms. Denise, she shared that when her clients ask her for medical advice or prescription refills, she says that she will get back to them before calling the nurse's line at CHC. When her call is returned and concern addressed, Ms. Denise then calls her client back or texts them with the answer provided by the CHC nurse. Mary seemed unaware that this process was in place, and may have instead assumed a more streamlined communication process across organizations than was actually the case. Mary and others who entered CHC via Ms. Denise's referral may receive faster answers to their medical questions if they contacted CHC directly.

## ***2.6 Discussion***

Findings suggest that different sets of social conditions across entrance pathways may have led patients to understand the role of CHC in their lives in particular ways and access different sorts of resources. That patients may experience such disparate socialization processes even within the same organizational setting may not be surprising to scholars of formal organizations. These findings also resonate with

sociological accounts of the reproduction of inequality through institutional processes (Bourdieu 1977; Schwalbe, Holden, Schrock, Godwin, Thompson, and Wolkomir 2000).

These findings underscore the complexity of patient treatment trajectories within healthcare organizations that may be set in motion before even the time of patients' first appointment encounters with their healthcare providers. This challenges an assumption in health disparities research that the healthcare provider-patient dyad may account for more variability in long-term healthcare treatment outcomes than other sorts of interactions between organizational actors and patients within particular healthcare settings. For example, in the theoretical model situating the role of public health and human service providers in the production of racial/ethnic health disparities proposed by van Ryn and Fu (2003), three patient-level characteristics (culture, class, and race/ethnicity) are treated as causal antecedents preceding clinical encounter outcomes (including patients' cognitive orientations to receiving care, their behavior in clinical encounters, and providers' beliefs about their social conditions and approaches to treatment). The present study's findings that organizational processes (i.e., intake procedures surrounding the processes by which individuals become patients) temporally occurring before clinical encounters provide an opportunity for future researchers to more systematically examine the role of organizational processes and situate these factors as a possible set of intervening mechanisms between patient-level characteristics and encounter-level characteristics that contribute to health disparities.

Both the roles of City Hospital's nurses and of Ms. Denise in the lives of new CHC patients resonates with extant research documenting the ways street-level bureaucrats at times operate as key "framing agents" to facilitate the improved socialization processes of low-income patients into altered understandings of their healthcare treatment and hopes for the future (Watkins-Hayes, Pittman-Gay, and Beaman 2012). Viewed another way, the difference that the presence of these key framing agents make in new patients' lives as they seek to identify and address possible barriers to accessing primary care also underscores the active, agentic approaches undertaken by patients to mitigate uncertainty in their everyday lives. It is important to reiterate, however, that neither Ms. Denise nor the community health nurses at City Hospital spoke Spanish. As such, neither Ms. Denise nor the nurses sent by City Hospital operated as framing agents for any Spanish-speaking patients to CHC. Discovering that the Spanish speakers were excluded from interacting with these individuals while both the food pantry through which Ms. Denise referred patients into CHC and City Hospital each had a sizeable population of uninsured Latino immigrants who were eligible for CHC's treatment resonates with prior research documenting the relative disadvantage of Latinos in the social safety net (Viruell-Fuentes 2007).

This finding also underscores the need for future research on New Immigrant Destinations in two ways. First, future research ought to systematically investigate how safety-net organizations seek to adapt to changing demographics of client populations,



and how these adaptations may attenuate or reproduce racial/ethnic inequality. Second, future research ought to explore the kinds of strategies undertaken by low-income non-English-speaking populations as they seek to navigate fractured safety net resources available in these settings.

One limitation to the insights that may be drawn through this study is that patients were not evenly distributed across entrance pathways according to class status. A wide body of research documents associations between class status, spoken language, and communication practices (e.g., Bourdieu 1990). Because class status and language ability were observed to vary across entrance pathways, it is impossible to identify a causal link between entrance pathways and disparate trajectories of patient socialization into CHC. Therefore, it is also plausible that the kinds of background characteristics of patients that varied across entrance pathways—like class status and spoken language—were the true drivers of observed differences in patient communication practices. For example, it is possible that patients who arrived at CHC’s “side door” via safety-net referrals learned to communicate unmet medical needs to Ms. Denise as a result of their experiences in this entrance pathway; but it also possible that these same patients may have learned at earlier points in life to communicate unmet medical needs to street-level bureaucrats rather than directly to higher-status clinicians. Conversely, patients who entered into CHC’s “back door” via ED referrals may have been taught to communicate directly with their medical providers as a result of this pathway, or they may have done

so because they expected to operate within this organization similarly to other professional settings in which they had experience.

Taken as a whole, this study calls attention to the need for policymakers and safety net organizations to develop targeted interventions to simplify eligibility criteria, streamline intake processes, connect clients to professionals who may be a resource enhancing their socialization into particular settings, and enhance the coordination of health-promoting resources across safety-net settings. Future research is needed to assess the relationships between these organizational dimensions and patients' efforts to mitigate the cumulative health effects of exposure to adverse social conditions. The present study also raises new questions for future researchers to address. Tach and Edin (2017) argue that at a broad level, social safety net policies "have expanded support for working poor parents quite dramatically, while the...safety net for the nonworking poor has all but collapsed." Private nonprofits in the healthcare safety net, it seems, may reflect this shift in policy as, for example, CHC tended to favor the working poor in its established patient eligibility criteria. The emergence of an alternative "side door" pathway to entering CHC for nonworking poor adults warrants additional research on the consequences of organizational change within safety net organizations in the lives of the poor. Further, more research is needed to clarify how race/ethnicity, gender, and class background—together with socialization processes into particular safety net

organizations—are related to the reproduction of inequality in long-term patient healthcare treatment trajectories.

## **3 Street-Level Rule Breaking and Organizational Transformation: A Conceptual Model**

### **3.1 Abstract**

This article presents an emergent conceptual model of rule-breaking and organizational transformation in private healthcare safety-net bureaucracies derived from a longitudinal ethnography of the privatized healthcare safety net in a setting which has recently become a New Immigrant Destination setting. I theorize that rule-breaking can be an obstacle or a benefit in efforts to improve patient care: while deviating from expected healthcare workplace courses-of-action may harm patients, they may also improve on established standards of patient care. This study focuses on “racial/ethnic resistance,” or workers’ rule-breaking in efforts to improve the racial/ethnic equality of client treatment. This type of rule-breaking is relatively unexplored in extant literature but essential to examine to better situate the agency of workers in the context of concrete organizational processes and client outcomes over time. Racial/ethnic resistance in healthcare safety net organizations involves workers engaging in workplace decoupling action that crosses formal boundaries delineating bureaucratically-sanctioned workplace routines on behalf of racially/ethnically subordinated patient populations. This decoupling behavior is met with heterogeneous organizational responses of punishment (when enacted among street-level bureaucrats who are seen by their managers to engage in “regular” resistance running counter to organizational goals), reward (when enacted among higher-status workers’ “creative”

and “collaborative” resistance), or bureaucratic transformation through the formal sanctioning of resistance via routinized recoupling (when enacted among organizational leaders’ “creative” resistance and “collaborative” resistance). Both workers’ resistance practices and organizational responses to them are consequential for the life course experiences of under-employed and uninsured patients. Exemplar cases from the ethnography are integrated in the discussion to illustrate components of the model. Three successive levels of resistance are described: regular resistance, creative resistance, and collaborative resistance. The conditions surrounding organizational responses to each type of resistance are also discussed. Implications for the study of life course inequality and recommendations for areas of future research are provided.

Key Words: Organizational change, private healthcare safety net, life course, intersectionality, health disparities

### **3.2 Introduction**

In an era of changing healthcare and welfare policies, how do structural gendered and racialized features of healthcare systems and welfare systems shape the institutional logics of private primary care safety-net settings and sanction the efforts of individual workers as they seek to improve their patients’ everyday lives? While under-employed uninsured adults in the U.S. represent a leading edge in the rising incidence of preventable chronic conditions and are in need of high-quality preventive healthcare interventions (Zhang 2012; Ayanian 2000; Vaidya et al. 2011), social scientists have made

little progress in understanding what is happening on the ground and in the daily lives of uninsured patients as they navigate the healthcare safety net. How are primary healthcare encounters in these settings created, situated, and experienced in contemporary American society? What social and economic advantages and disadvantages do uninsured adults experience that influence the courses-of-action they take in their healthcare usage, and how are these strategies shaped by interactions with healthcare safety net organizations? These questions and others have been ardently raised by medical sociologists and demographers who are seeking explanations for why access to preventive healthcare and related medical encounters among uninsured adults (as well as the broader American population) have become so diverse and now require, more than ever, innovative and perhaps unconventional approaches to address current gaps in knowledge about the forces driving and characterizing these encounters (Holden et al. 2015).

Indeed, the need for unpacking preventive healthcare encounters, particularly among low-income adults in safety net healthcare organizational settings, has been hastened by the sheer magnitude of change and variability in prevailing types of health insurance coverage, preventive healthcare access and usage, and the distribution of healthcare resources through public and private nonprofit safety-net organizations. Although some have called for researchers to pay closer attention to the role of place in shaping population-level health disparities (White et al. 2012), rarely have researchers

investigated how preventive healthcare is understood and experienced by workers and patients together in particular settings. Recent empirical work on access to and use of preventive healthcare among the uninsured frequently involves studies of the effects of macro influences, such as urban neighborhood poverty, residential segregation, or patterns of safety-net exclusion (Sandri et al. 2014; Laiteerapong et al. 2014; Chan et al. 2012; Stone et al. 2015), or documenting correlations between lack of health care coverage and poor health outcomes (Zhang et al. 2012) or disparities in preventive service usage rates among the uninsured (Holden et al. 2015). While this body of research is important, these studies fail to address how inequality is reproduced through interactive processes within particular social settings, the focus of the present study (following Schwalbe et al., 2000).

Few have investigated the organization of work in private safety-net healthcare settings. However, placing these settings more at the center of efforts to systematically investigate the role of the safety net in the life course experiences of under-employed and under-insured families is warranted given privatization, delegation, resource fragmentation across organizations, and the speed of policy change characterizing the contemporary era. Making sense of private safety net organizations is particularly important given the ways organizational processes in these settings may importantly diverge from their public counterparts. Relatively unbounded by governmental oversight compared to their public counterparts, private nonprofit settings may adapt

more quickly to changing policy environments. In comparison to their public counterparts, there may also be more complex and contradictory institutional logics at play, including those surrounding what it means to be a private, faith-based, healthcare, and human service organization. Together, this flexibility and complexity may provide increased pathways to shape quickened organizational change. Therefore, it is especially important to examine how private settings respond to the efforts of individual workers who seek to improve their patients' everyday lives.

The purpose of this article is to address this gap by describing how structurally gendered and racialized features of governmental policies and population dynamics in particular geographical settings shape worker practices in particular private healthcare safety net organizations and correspond with cumulative health disadvantage experiences of the under-employed and uninsured patients in these settings. With regard to the ways structurally gendered and racialized features shape individuals' cognitions, I find it useful to draw on insights from research on the role of cognitive cultural schemas and racial ideologies applied to delineate who is *deserving* of care (Moffitt 2015) amid extant social inequalities (Bonilla-Silva 1997, 2001).

Together with schemas and ideologies, institutional logics (Thornton and Ocasio 2008) provide workplace cultural scripts guiding workers' cognitions about patient care and the roles particular healthcare safety net organizations should play in the wider community. These scripts, as intersecting cognitive structures (Sewell 1992), can be



deployed in tandem with leveraged social capital resources in de-coupling (Meyer and Rowan 1977) practices of rule-breaking when already-established and routinized workplace practices are understood as failing to adequately address morally-deserving patients' unmet needs. Intersecting structures across an organizational hierarchy shape not only when and how de-coupling is practiced among "street-level" workers (Watkins-Hayes 2009; 2011), but also organizational leaders' responses to de-coupling. While workers are expected to generally follow bureaucratically-sanctioned organizational processes, they may also creatively act as agents of resistance to the status-quo when faced with integrating structures that stand at odds with their perceptions of bureaucratically-sanctioned rules. At these times, they seek through de-coupling behavior to leverage their resources to improve patient care. As leaders continually seek to clarify their organization's role in the community and iteratively adapt to better address unmet patient needs, organizational change unfolds in part as a response to rule-breaking. The de-coupling practices of individual workers may be met either with punitive sanction or reward, and potentially adoption in a dynamic, iterative organizational process that unfolds over time and in the context of its particular social and geographical setting. I elaborate this theory by presenting an emergent conceptual model, drawing on exemplar cases from a longitudinal ethnographic case study of Compassion Health Clinic (CHC), a faith-based primary care safety net healthcare organization located in a geographical setting which has recently become a New

Immigrant Destination (NID). Ethnographic fieldnotes and recorded interviews conducted with volunteer workers, paid staff, and patients document individuals' perspectives and experiences in the context of their everyday lives and organizational processes unfolding from 2011-2016. At CHC, paid and volunteer workers found themselves in a dynamic organizational space filled with complex and contradictory institutional logics, schemas, and ideologies. Amid this uncertainty and the presence of multiple cultural scripts from which to draw, workers perceived unmet patient needs and acted to address them, at times in opposition to the formal rules and regulations governing patient care at this setting. In this way, workers *resisted* the formal rational-legal structures of routinized, bureaucratically-sanctioned organizational processes that dictated patient care which they perceived to exacerbate inequality when they deemed it necessary. But when workers resisted what they saw to be obsolete, inefficient, or racist bureaucratic processes, their efforts were either met with punitive sanction or rewarded. As leaders acted to re-consolidate power and re-constitute bureaucratic legitimacy, some rule-breaking was punished, while other rule-breaking was rewarded either informally or via formal adoption into new, formally-sanctioned organizational processes governing patient care.

### **3.3 Background**

In the years following welfare reform, research documenting the rising relative significance of private non-profit safety net organizations providing welfare resources

and social services has proceeded at a faster rate than research on private nonprofit healthcare organizations. This stream of research, together with more recent efforts to understand the organizational consequences of Medicaid managed care (Waitzkin et al., 2002) and targeted responses to specific health conditions such as HIV/AIDS (Watkins-Hayes, Pittman-Gay, and Beaman 2012; Watkins-Hayes 2014), provide useful theoretical insights regarding the possibilities for organizational changes in and life course consequences of private healthcare safety net organizations in the post-ACA era.

### **3.3.1 Safety Net Organizational Resource Environments following Welfare Reform**

The years surrounding and following welfare reform in the late 1990s have been marked by policymakers' imposition of increasingly punitive (Wacquant 2009) and disciplinary (Soss, Fording, and Schram 2009) restrictions on the distribution of public safety net resources. Simultaneously, safety-net resources have been increasingly "delegated" (Morgan and Campbell 2011) to nonprofit organizations in an era marked more broadly by neoliberal privatization. The passage and partial implementation of the Affordable Care Act (ACA) introduced another set of complications characterizing the populations served by safety net organizations and their wider resource environments, as some states elected to expand Medicaid eligibility, effectively closing the "gap" in health coverage among populations eligible for public assistance, while others did not in the wake of the financial crisis and economic recession.

On the ground, the provision of public safety-net resources has eroded in the wake of welfare reform, leaving salient unmet needs in the lives of the poor. One early effort to understand organizational responses to Medicaid managed care found that the introduction of managed care placed additional resource constraints on public safety net healthcare providers in community health centers (Waitzkin et al., 2002). In their multi-site ethnographic study of nonprofit social service agencies in the wake of welfare reform, Edin and Lein found that “although nonprofit social service agencies are a crucial part of many low-income mothers’ economic survival strategies, they cannot come close to substituting for the eroding public safety net” (1998:541). “Because of their fiscal constraints,” Edin and Lein explain, private nonprofit organizations “targeted their funds to specific groups and within specific service domains” to achieve “legitimacy and credibility in the eyes of both funders and the community at large” and “to give their own staff, volunteers, and board members a sense that they were doing something good with their limited resources” (1998:560-561). Although targeting of resources was employed to establish organizational legitimacy, it also meant that poor families had to navigate a complex and fragmented web of organizations.

Research also documents heterogeneous effects of changing policies and differing safety net bureaucratic governance structures on broader processes of cumulative disadvantage in the life course experiences of under-employed and under-insured families. For example, recent research finds that the exacerbating effects of

fragmentation on the reproduction of life course inequality may be somewhat counteracted through organizational interventions re-constituting a more integrated array of safety net resources and increased organizational ties. At these times, clients of safety-net organizations come to experience these organizations as “framing institutions” that “facilitate or impede a ‘turning point’ that represents a marked change in coping strategies” (Watkins-Hayes, Pittman-Gay, and Beaman 2012: 2030). Experiencing safety-net organizations as framing institutions and interacting with key framing “agents” within particular organizations who facilitate this experience may alter patients’ longer-term trajectories of physical health, mental health, and socioeconomic mobility.

### **3.3.2 Theorizing Institutional Logics and Organizational Change in New Destination Safety Net Healthcare Settings**

With respect to how prior research on organizational processes contributes to the present investigation of the healthcare safety net in a NID, it is useful to begin by applying theoretical insights from research on institutional logics and complex organizations (Thornton et al. 2012; Perrow 1986; Hasenfeld 2010). For example, a faith-based nonprofit private primary care clinic in the healthcare safety net can be understood as a unique type of formal organization containing multiple religious, welfare, and healthcare institutional logics. Some of these logics may compete with one another and diverge from the constellations of institutional logics at public healthcare safety net settings such as federally-qualified health centers. The distinct combination of

organizational logics at work within particular workplace cultures and across these settings may lead to distinct organizational processes producing inequality among workers and patients.

Hasenfeld (2010) theorizes that human service organizations are social settings uniquely characterized by the importance of client-worker relations, emotional labor, and the predominance of women as human service workers. Racial inequality has typically been a focus of individual-level mechanisms in organizations research, and scholars have recently argued that detailing the meso-level mechanisms that contribute to racial inequality is an under-developed area (Reskin 2000; Wingfield and Alston 2014; Wooten and Couloute 2017). Other streams of research underscore the importance of understanding bureaucratic routines governing the everyday performance of work amid intersecting systems of class, racial/ethnic, and gender inequality (West and Zimmerman 1987; Acker 1990; Jackson 2001; Warren 2001; Markus and Moya 2010; Wingfield 2009, 2013; Ray 2017). An emerging area of research details distinctly organizational-level features and processes through which racial inequality is reproduced (Ray 2017; Eagle, Mueller, Proeschold-Bell, and Rivers 2017). Together, these literatures underscore the possibility that the bureaucratization of patient care at the site of the formal organizational articulation of client eligibility policies and expectations for worker routines in the private healthcare safety net can also be organized in ways that

reproduce racial/ethnic inequality by disproportionately conferring material resources on superordinate racial/ethnic groups and disadvantaging subordinate groups.

Research on organizations provides helpful conceptual tools for understanding how the actions of workers who break workplace rules and deviate from approved workplace routines may relate to organizational change over time. Bureaucratic rules may be broken through “decoupling” practices at the site of the worker-patient interaction. Decoupling is usually seen by race scholars to perpetuate inequality through racial tracking through organizations in spite of formally-articulated commitments to equity (e.g., Skrtic 2003; Ray 2017). However, decoupling can also unfold in ways that may moderate the harmful effects of interlocking systems of oppression if, for example, formal bureaucratic rules reflecting anti-Black racial ideologies are resisted by workers who instead espouse alternative understandings of Black patients as (1) unfairly materially disadvantaged through their subordinate class status within a racialized social system which tends to afford a superordinate White racial class material resources and (2) morally deserving of workers’ leverage their resources to meet Black patients’ unmet needs.

I draw on recent streams of research on organizations to help conceptualize the possibility that multiple sets of gendered and racial workplace rules may simultaneously operate in the same organizational setting (following insights from race and gender scholars including Acker 1990; Markus and Moya 2010; Wingfield 2009, 2013; Ray 2017).

It is important to note that there is no consensus among organizational scholars regarding the long-term sustainability of contradictory institutional logics within particular settings, although a few recent studies provide useful conceptual tools for the present study. Pache and Santos (2010) argue that decoupling is unsustainable in contexts where conflicting institutional logics compete over long periods of time due to the emergence of coalitions of workers representing these competing organizational ideals. Pache and Santos (2013) proceed to theorize that “selective coupling” may be a more organizationally-sustainable form in which *intact elements* of conflicting institutional logics are fully embraced and find that this process occurs in “hybrid organizations” that resist the adoptions of decoupling or compromising. Conversely, others suggest that competing institutional logics may well exist for long periods of time as collaborative relationships are developed to manage rivalries (Reay and Hinnings 2009) or that competitive and cooperative relationships among coexisting institutional logics in particular organizational settings can provide pathways for the concurrently-occurring influence of multiple institutional logics on workplace roles (Goodrick and Reay 2011).

Two recent studies provide useful conceptual tools for understanding how decoupling practices may lead to organizational change. Hallett (2010) finds that “recoupling” is possible via processes that emerge to facilitate closer linkages between institutional myths and organizational practices that were once loosely connected within



an organization. Ocasio, Loewenstein, and Nigam (2014) suggest that sets of communicative events among individual workplace actors, when distributed throughout organizations and institutional fields, can converge on systems of categories so as to yield the meaningful and durable principles that constitute institutional logics. Applying these insights to the case of bureaucratic change in the context of private healthcare safety net organizations, I theorize that if racial resistance decoupling practices are embedded in an array of communicative events that justify their existence to organizational leaders as valid behaviors that creatively address formerly unmet patient needs while integrating workplace culture, resistance may become recoupled and legitimated through the emergence of new bureaucratic routines.

Investigating how the reproduction of racial/ethnic inequality relates to organizational decoupling and recoupling in the private healthcare safety net in a New Immigrant Destination (NID) is particularly warranted, as a burgeoning body of research on NIDs has emerged documenting the ways racial/ethnic relations in these settings are “in flux.” Additionally, NID settings may provide a microcosm for understanding changing racial stratification processes in the U.S. more broadly as it changes from a bi-racial system to a tri-racial system (Bonilla-Silva 2004). In this new racialized social system, Bonilla-Silva predicts that three racial classes will emerge: a superordinate White, a middle strata he describes as “honorary White,” and a subordinate “collective Black.” A small but growing body of ethnographic research has

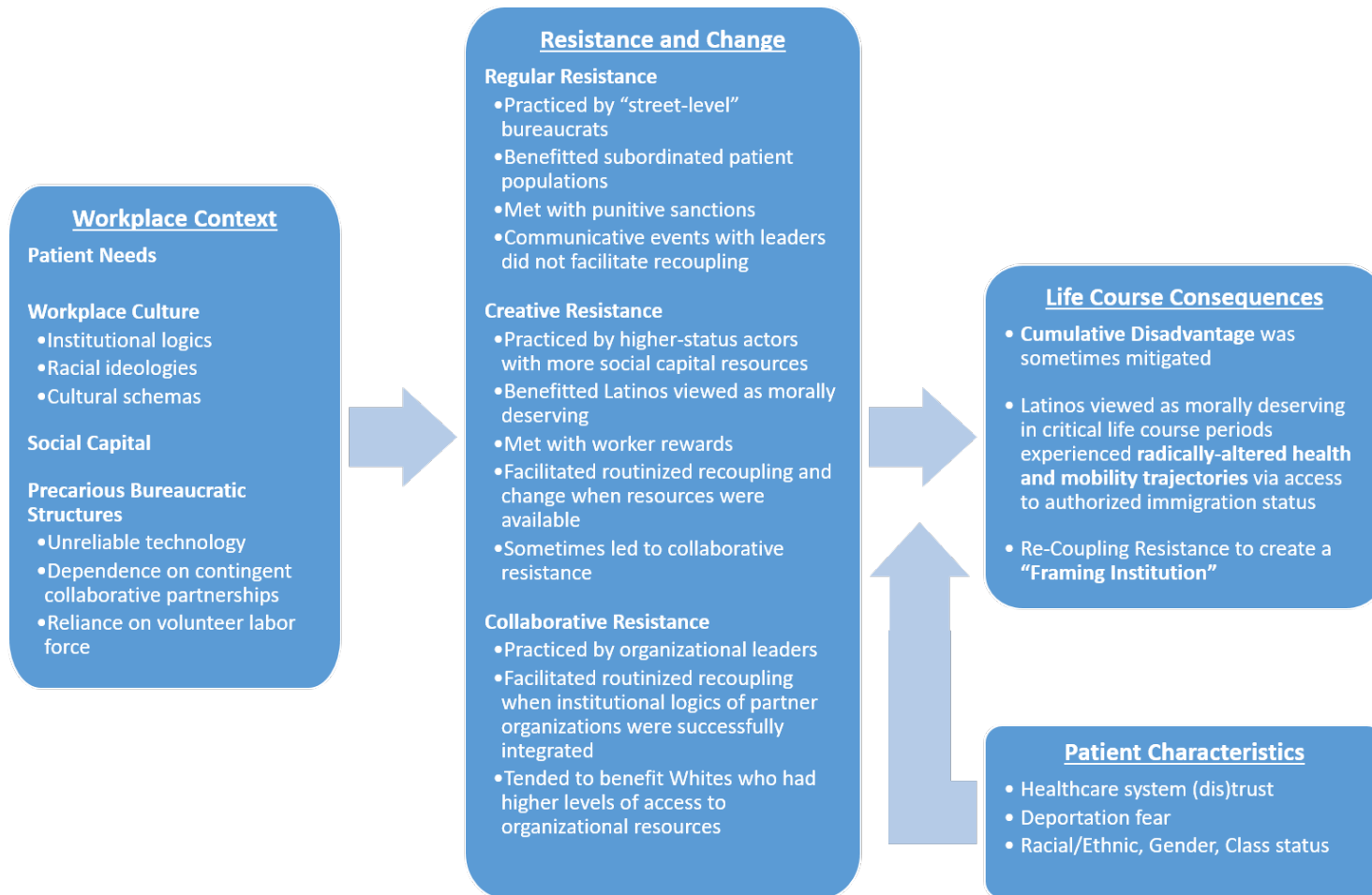
explored how poor Latino families experience race relations in NIDs (Marrow 2009; Gómez and López 2013) and the impact of unauthorized immigration status on family well-being (Gonzales 2011; Abrego 2011). Sociologists have documented the importance of studying social interaction within particular settings as a vehicle contributing to the reproduction of inequality (Bourdieu and Passeron 1977; Schwalbe et al. 2000).

I describe the conceptual model below with explicit referent to the NID setting in which the ethnography and exemplar cases are situated in an effort to advance the state of sociological understandings of how racial stratification relates to organizational change. Theories of cumulative health disadvantage have posited that poor health is partially the result of a series of interactions between disadvantaged individuals and adverse social settings over long periods of time (Shuey and Willson 2008; Shim 2010; Dannefer 2003). The present study seeks to contribute to this literature by theorizing the consequences of low-income and uninsured adults interacting with dynamic safety-net healthcare systems with explicit referent to longer-term processes that unfold across the life course experiences of America's poor. This investigation is warranted as a necessary step in efforts to shed light on the dynamics patients and their families may face as they navigate these systems in the context of their everyday lives.

### **3.3.3 Conceptual Model and Ethnographic Approach**

Figure 1 presents the conceptual model of street-level racial resistance and organizational transformation in private healthcare safety net bureaucracies. The model

emerged from an iterative process in which the bureaucratic procedural mechanisms, cognitive structures, and ecological factors involved in street-level racial/ethnic resistance and organizational change were identified in a content analysis of recent streams of empirical research and translated into a working conceptual model. The model was then tested for credibility and revised using data from a longitudinal organizational ethnography of a private nonprofit healthcare safety net clinic in a time period immediately following the passage of the Affordable Care Act and in a geographic setting which had recently become a NID.



**Figure 1: A Conceptual Model Linking Racial/Ethnic Resistance, Organizational Change, Patient Characteristics, and Life Course Consequence**

This ethnography involved longitudinal, team-based fieldwork comprising in-depth interviews with volunteers, paid staff, and low-income and under-insured patients in private healthcare safety net organizations and participant observations in the everyday activities of these settings. Everyday activities observed in these settings included the daily routines of low-, middle-, and high-occupational status staff, contractors, and volunteers; meetings among boards of directors; staff lunches; holiday parties; large-scale fundraising events; worker-patient interactions in common areas, and interactions among patients and their families preceding, during, and following their interactions in waiting rooms and parking lots. Although this fieldwork did not include direct observations of interactions between healthcare providers and patients as they received treatment in exam rooms, it did include the analysis of patient interview respondents' electronic medical records (EMRs). EMRs documented patients' scheduled and missed appointments, participation in health educational programming and receipt of extra-organizational resources, and long-term treatment trajectories from the date of their entrance into private healthcare safety net organizations through the date marking the completion of the fieldwork. Analyzing EMRs together with other ethnographic and interview data sources in a systematic and transparent process captured by reflexive fieldnotes, analytic memoing, and audio-recorded data analysis sessions among teams of ethnographers provided the means by which the emergent conceptual model could be

validated and understood with reference to its consequences on patients' long-term health and mobility trajectories.

Representative exemplar cases drawn from this ethnography, focusing on the organizational dynamics observed at CHC, are integrated into the discussion to illustrate the relationship among components of the street-level racial/ethnic resistance and organizational transformation process. This method adopts established procedures for approaching exemplar cases which, as "representative illustrative cases, are an established form of integrating ethnographic data in conceptual discussions as they give readers a sense of the reality of particular experiences, the *verstehen* or viewpoint of the actors, and provide empirical verification of the patterns of behaviors discussed" (Burton 2007:333; see also Strauss & Corbin, 1998).

I follow Burton's (2007) structure for clarifying an emergent conceptual model through the analysis of ethnographic data. It is important to note that while worker rule-breaking may be undertaken in ways that improve or worsen patient treatment, no negative cases were contained in the data in which patients were harmed by rule-breaking. As such, this conceptual model focuses on explicating the kinds of rule-breaking that was observed at CHC to benefit patients and contribute to a more equitable standard of care for racially/ethnically disadvantaged patients. First, I present the model by specifying the aspects of workplace context and worker attributes that the ethnographic data suggested were related to the performance of de-coupling racial

resistance practices. Second, I describe three successive forms of resistance observed at CHC (typified as “regular,” “creative,” and “collaborative”) and the features of the dynamic organizational processes in which these practices were contextually embedded, which seemed to matter most in influencing outcomes for workers and organizational change. Third, I outline the health and mobility outcomes for patients that emerged in the data, arguing that organizational responses to racial resistance, apart from the workplace outcomes they shaped for individual workers, can—through the routinization of resistance in processes of re-coupling organizational transformation—simultaneously produce mechanisms that both dampen and exacerbate the effects of wider, extra-organizational interlocking systems of racial, gender, and class oppression in the life course experiences of the low-income and under-insured patients who utilized CHC over time.

### ***3.4 Workplace Context and Racial Resistance: Patient Needs, Workplace Culture, Social Capital, and Precarious Bureaucratic Structures***

As illustrated in Figure 1, certain circumstances in bureaucracies can lead to decoupling actions of racial resistance. Aspects of workplace context that appeared most influential include patient needs, workplace culture, workers’ social capital resources, and precarious bureaucratic routines.

### **3.4.1 Patient Needs**

Workers who took on practices of racial resistance in their organizational setting did so in direct response to specific patient needs. Patient needs typically included securing referrals for specialty healthcare treatment, accessing costly prescription medications, accessing socioeconomic resources beyond the scope of the organization's relatively limited resources, paying for patient appointments out of pocket or marking their bills as paid-in-full, and serving as an emotional confidant for patients or their family members as a "stop-gap" mental health provider. Additionally, workers who spoke Spanish in the ethnography were expected to address unauthorized immigrant patients' special needs around communication and traversing a dominant culture characterized by complex mechanisms of formal exclusion from public healthcare resources, welfare resources, and varying levels of deportation threat in the context of a restrictive and criminalizing immigration policy regime (Donato and Rodríguez 2014; Mueller and Bartlett 2017). Implicit among workers adopting rule-breaking constituting practices of racial/ethnic resistance is that the perceived needs of disadvantaged patients can supersede the skills, training, and formally routinized organizational structures at private healthcare safety net organizational bureaucracies.

### **3.4.2 Workplace culture: intersecting institutional logics, racial ideologies, and cultural schemas**

Dimensions of workplace culture are inherently tied to patient needs and represent the operating principles and scripts that guide workplace functioning. Thus,



workplace culture plays a critical role in whether a worker takes on de-coupling racial resistance practices or not. Three types of cognitive structures are relevant—institutional logics, racial ideologies, and cultural schemas.

### **3.4.2.1 Institutional logics**

Institutional logics in complex organizations provide a set of cultural scripts enabling workers to make sense of their everyday workplace roles in light of transcendent organizational goals and over-arching features of an organization's identity in the context of the wider community within which it is embedded (Thornton et al. 2012; Perrow 1986; Hasenfeld 2010). For example, a faith-based primary care clinic in the healthcare safety net can be understood as a unique type of formal organization containing multiple religious, welfare, and healthcare institutional logics. Some of these institutional logics may stand at odds with one another, and how institutional logics are combined in workers' cognitions with racial ideologies and cultural schemas (described below) as they make sense of their work and the patients they serve may lead to distinct organizational processes producing racial disparities among workers and patients.

Multiple institutional logics were present in the processes through which workers made sense of CHC's role in the wider community and in the everyday experiences of their patients. These institutional logics conflicted with one another and provided enough bureaucratic ambiguity to afford individual workers opportunities to take on different strategies for patient care, resisting routinized practices in the name of

organizational identities that transcended rules governing their everyday workplace roles. The ways individual workers made sense of these institutional logics and sought to resist wider, structural forces shaping patient health and mobility disparities were generally patterned by occupational class status, racial status, and gender status within the organization and in relation to the statuses of other workers. Even in the few times when workers of different statuses understood institutional logics in similar ways and undertook similar sorts of strategies for resistance action, they encountered punishment or rewards according to racial, gender, and occupational class status within CHC's organizational hierarchy. This resonates with findings from prior research documenting organizational processes governing the performance of race and gender in organizational settings (West and Zimmerman 1987; Acker 1990; Jackson 2001; Warren 2001; Markus and Moya 2010; Wingfield 2009, 2013; Ray 2017).

#### **3.4.2.2 Ideologies and schemas**

Racial ideologies involve individual-level racial attitudes cognitively applied by individuals to make sense of extant racial disparities in access to material resources (Bonilla-Silva 1997). Racial ideologies are not necessarily anti-Black racist attitudes, although anti-Black racism is a commonly held racial ideology especially among superordinate members of the dominant white racial class in the post-Civil Rights era characterized by colorblind racism (Bonilla-Silva 2001; 2010). Instead, racial ideologies can be *any* set of cognitions descriptively employed to make sense of extant racial

inequality. For example, CHC workers often made sense of racial inequality among patients' social class conditions, likelihood of missed appointments, and health conditions by employing racial ideologies that placed oppressive structural forces and systematic, institutional racism as root causes of racial inequality.

The reification of sub- and super-ordinate classes in a racialized social system occurs at the individual level as individuals make sense of their status within a racial hierarchy and justify their relative social position within it. In this way, the set of descriptive tools provided by racial ideologies can act to situate sub- and super-ordinate racial classes within particular organizational settings and justify the reproduction of organizational forms which reproduce inequality along axes that reflect racial inequality of the wider geographical and social settings in which organizations are situated. While racial ideologies held by individuals outside these organizations may ascribe the cause of missed appointments to patients' deviant health behavior or laziness, within healthcare safety net organizational contexts, the same patients may be re-categorized as contingent members of a super-ordinate class of individuals who have achieved "patient" status (thereby seen as relatively elite among other members of sub-ordinate classes), as ideologies are, for example, employed to interpret missed appointments as caused by structurally-determinative social hardship conditions including transportation barriers, being stopped by the police, and deportation fears not faced by higher-status Whites.

Cultural schemas regarding which patients constitute the “deserving poor,” either within a particular healthcare safety net organization’s patient population or in the wider community within which an organization is embedded, provide cognitive tools for workers to justify expanding or limiting the scope of their interactions with patients. Schemas, if widely held among members of an electorate, may also provide a vehicle for wider social policy change (Steensland 2006). Ideologies and schemas provide a cognitive toolkit for workers to challenge reified racial ideologies and to imagine new expressions of organizational processes that upset bureaucratically-sanctioned workplace routines.

Workers integrate the cognitive structures of institutional logics, racial ideologies, and cultural schemas as they continually seek to better address patient needs. If the way workers integrate these structures resonates with organizational leaders’ own sense-making of patient needs and their hopes for the organization’s role in the community, workers are rewarded for their resistance and bureaucratic routines may be transformed as re-coupling occurs via the formal adoption of resistance practices into bureaucratically-sanctioned workplace routines. However, if workers’ integrations of cognitive structures conflict with leaders’ own sense-making processes, individual workers are met with punitive sanction and bureaucratic governance structures may dynamically adapt in leaders’ efforts to re-establish their validity by introducing widespread employment terminations, the re-organization of workplace roles, and new

methods of oversight to more effectively discipline worker routines and reduce the likelihood of similarly-patterned de-coupling practices in the future.

### **3.4.2.3 Social Capital**

When they resisted the established bureaucratic order, higher-status workers were more likely to draw on enhanced social capital resources than lower-status workers who had fewer social capital resources. By drawing on social capital resources, high-status workers were able to resist routinized processes in ways that mitigated risk and their efforts were more likely to be organizationally-legitimated as "creative" or "collaborative." Workers with fewer social capital resources resisted more *often*, as they were more frequently interacting with patients in formal non-medical bureaucratic channels, and their lower social statuses within the organization may have led them to empathize with disenfranchised patients who faced yet another set of bureaucratic hurdles to surmount in CHC's rules and regulations. However, their "regular resistance" efforts were also more frequently met with negative sanction than other types of resistance.

Workers with higher social capital resources sometimes leveraged these resources to enhance the volunteer labor force. More than half of the volunteers were recruited via professional networks, which is in line with prior research on volunteering in charitable organizations (Boezeman and Ellemers 2008). Five volunteer mental health professionals were recruited by one who sought out this setting for herself as an

opportunity to, in her words, “continue giving back to the community” in her retirement. Two physicians and one nurse practitioner sought out this setting on their own and all of them tried to recruit other volunteers. One ophthalmologist who had been recruited by another enlisted the assistance of a nurse on staff at his private practice to assist in conducting eye exams at CHC once every few weeks.

#### **3.4.2.4 Precarious Bureaucratic Structures**

Workers at CHC constantly adapted their organizational routines to mitigate inefficiencies caused by insecure and unstable technological resources and volunteer labor sources with widely varying skillsets and needs for supervision. Together, these factors and others like them characterized an environment in which disruption and inefficiency was commonplace. In this context, rule-breaking was somewhat expected, as workers across occupational strata held common frustrations regarding the precarious and inefficient provision of patient care in this setting relative to what they imagined occurred in public healthcare safety net settings and hospitals.

I observed three days in the winter of 2015-2016 when the EMR system was down. Each day that it was down was the workday immediately following a major winter storm. Not having a means to chart patient healthcare encounters or to distribute prescription medications, the clinic was closed each of these days. Workers were frustrated as they frantically attempted to re-boot the system to no avail, as patients who

had traversed ice and snow to see their doctor or acquire prescription refills waited patiently before leaving disheartened.

At other unpredictable times, the EMR system would be slowed or fully offline. I asked a manager about the current technology system. He shared, "Right now, it's as though we're like a pirate with a peg leg hobbling around. The tech guys come in on Wednesdays, but they are asking us to bite down on a wooden spoon while they work on the peg-leg. What we need are some running blades like Oscar Pistorius has." He explained that a nearby hospital had promised to donate some used computer equipment and provide the means for a system-wide upgrade from the current outdated EMR system to a new one which would enable a faster, more reliable, and more secure method for housing and managing EMR data across organizations.

I asked the director of counseling services how his volunteer workforce of mental health professionals and the EMR system are related in his day to day work. He expressed frustration as he explained that volunteers at times seem like more trouble than they are worth: "It creates a tension of them not likely to use the electronic charting correctly and it creates more work for me to have to step in. Sometimes, they don't want to follow instructions and this creates an issue. How do you address a volunteer in a way that respects them volunteering?" He continued, "Some volunteers are better than others, it's really hit-or-miss. Like, some of the [interns] from [a nearby university], some

of them are awesome and some just do it for the credit, so what the fuck am I going to do then? It's really hit or miss."

At CHC, there are four wireless internet networks: two downstairs, and two upstairs. Frequent outages in one or more networks at a time lead to frustrations and work interruptions. One morning, the director of development (DD) paged the volunteering coordinator (VC):

DD: "Hey, is your wireless working?"

VC: "I think so, why?"

DD: "I don't know, mine says it's down again."

VC: "Huh, are you on [name of network]? I'm on that one and it seems to be going fine."

DD: "No, I don't think I'm in range for that one. Ok, thanks. I'll just wait it out. Maybe I'll hit reset on the box."

After this, the director of development decided to "wait it out," giving up on trying to connect to the internet and working offline instead. After a few minutes, she pressed the "reset" button on the router (which she called "the box") and the problem seemed to resolve itself about 10 minutes after that time. During this time, she and workers at workstations nearby did not have access to the internet or to the EMR system.



Interruptions in internet connections were fairly commonplace at CHC, to the extent that workers came to expect internet connection problems, software glitches in the EMRs system, system crashes, and other computer hardware-related disruptions to work as a regular occurrence. In the words of one worker, “technological SNAFUs are normal here but would be unheard of at a place like [a large hospital] down the street.”

### **3.4.3 Organizational Routines, Resistance, and Change**

It is plausible to expect rule-breaking to be undertaken in clinical environments in ways that may lead to patient harm as well as benefit. However, I was somewhat surprised to find that rule-breaking in ways that led to patient harm (i.e., exacerbated disparities) did not occur in the ethnographic data that were used to test and refine the conceptual model. Each of the three types of rule-breaking observed in the ethnographic data were oriented towards improving clinical outcomes for racially/ethnically disadvantaged patients.

#### **3.4.3.1 Regular Resistance**

Regular resistance work was undertaken by street-level bureaucrats at CHC, composed of lower occupational-status workers who were Black or Latino. These workers, who were the face of an inefficient bureaucracy to patients often desperate to maintain their status as patients at CHC, often broke rules to soften the sharp edges of this bureaucracy in the lives of its patients.

Regina, for example, was a receptionist who often took it upon herself to provide solutions to patients' needs, even if it meant advising them to seek other resources outside CHC or its formal collaborative partners. In doing so, she was less productive than other front desk workers, and faced constant criticism by managers who saw her as lazy or intentionally slowing down the pace of CHC's bureaucratic routines. One day, a mother and her 18-year-old daughter approached Regina at the front desk. After speaking with them rapidly in Spanish for five minutes, she called a physician in the clinic. On the phone, her voice quickly softened, and her eyes lowered. As she hung up the phone, she shook her head and appeared to be very disappointed. She turned away from the desk for two minutes, wrote something down on a piece of paper, and handed this piece of paper to the two women as she spoke with them for another two or three minutes before wishing them luck and saying goodbye. Then she turned to me to explain what had just happened, her voice still soft, as it was on the phone with the physician, "I—I had to turn her back. I wouldn't have wanted to, she's 18 with a lump on her breast, but I had to." I asked, "So, what did you have to do?" Regina turned to me, raising her voice and speaking more rapidly, as she had before communicating with the physician. She recounted the events that had just transpired, frustration in her voice:

"Send her *away!* Send her to another clinic. I at least gave her information on where she might be able to go. I don't want to waste her time with an appointment here if I know she can't get a referral... We can't refer her. If she

were to need a mammogram, it's very complicated because she's only 18. And if she doesn't have the cancer in her family, if she doesn't have a family history of it, it's very hard for us to refer."

I learned that the piece of paper Regina handed to the mother was a list of other clinics that Regina thought might be better options. Though the physician had not instructed her to do so, she took it upon herself to seek to connect a patient with other resources than those housed at CHC. Regina carefully explained where the other clinics were located and which buses to take to each one before asking the mother if she had any other questions or needed anything else from her. The mother insisted that they would be fine and thanked Regina for her help before leaving CHC.

Though Regina and other street-level bureaucrats like her were frequently frustrated at the lack of infrastructure within CHC to meet the needs of prospective patients like this one, they did not seem to mind setting aside time out of their work days to connect community members with what she saw as the best resources available to them. I repeatedly observed Regina devote much time and energy in her efforts to understand the felt needs of patients of color in their own terms and thinking of creative ways to meet these needs in the face of broader systems of conferring disadvantage. Regina engaged in long conversations with these individuals about unmet needs and the availability of community resources, and these conversations frequently lasted for extended periods of time. Her managers expressed frustration at the amount of time

Regina spent with each case, not recognizing these conversations as the kind of meaningful work that might be undertaken at CHC if it had a social worker on staff. Regina's efforts were not recognized as a legitimate use of her time by Regina's managers, who perceived her as not appropriately managing her time; ultimately, Regina was fired for her perceived inefficiency in the workplace.

Like Regina, other nonwhite street-level bureaucrats at CHC experienced racial work as they felt that they were asked to be a Black "face" of the organization when managers expressed a need to enforce eligibility criteria through the imposition of punitive sanctions on some patients. Financial burdens faced by patients intersected with the racial work of these workers and regular resistance practices periodically occurred, which placed street-level bureaucrats at risk of themselves encountering punitive sanctions. Tasha, for example, shared with me that she was frequently called on to enforce the "three strikes" rule, in which patients were dropped from the clinic if they failed to make their appointment three times over the course of a year. She told me that she had become frustrated with the rule over time, the more she interacted with patients, because it seemed to just impose another hardship on patients, this time in the form of erecting a barrier to healthcare access for those who had already overcome the challenge of finding a healthcare setting to meet their needs. So she started pushing off these meetings indefinitely and told me that in some cases, she deleted patient bills when they reached the threshold that meant dropping them. This became an accounting

problem for the organization, and when she was found out, Tasha was terminated from her job.

Regular resistance was not met with organizational change, even though regular resistance efforts were continually deployed to seek to reduce some of the burdens faced by patients. Because high-status leaders viewed the bureaucratic rules that were being broken as having a symbolic value over and against their importance in the lives of patients, regular resistance efforts failed to provide a vehicle for leaders to integrate structures to change these bureaucratic routines. Jennifer, the director of development at CHC, explained:

“[patient bills are] more symbolic and [have] to do with the public front of the organization, and less to do with patient needs or meeting the bottom-line financial costs incurred by the clinic for patient treatment.”

Workers who engaged in regular resistance were viewed as deviant and faced gendered micro-aggressions and punitive sanction for their decoupling. Their communicative interactions (Ocasio, Loewenstein, and Nigam 2014) with organizational leaders were seen as complaints rather than legitimately coupled with an institutional logic. One manager classified this group as “those people...who just don’t seem to get it and aren’t really good team players.” When one leader in the organization left another manager’s office, she stated, “well, I’m headed up to go check on the help,” not aware that anyone other than this manager had heard her disparaging sexist and anti-Black

racist epithet for those workers who did not seem to be “good team players” in the dominant workplace culture of CHC.

#### **3.4.3.2 Creative Resistance**

Creative resistance, as opposed to regular resistance, was met with reward and led to direct bureaucratic change or was adopted as collaborative resistance in bureaucratically-sanctioned processes aimed at improving patient care. For example, medical professionals at times engaged in mental health counseling treatment beyond the scope of their training, contributing to organizational inefficiencies manifested in longer wait times for patients with scheduled appointments. Sometimes, these slowdowns resulted in the cancellation of appointments scheduled late in the day because the medical provider staff was so far behind schedule. When faced with bureaucratic pressures to keep to the schedule and limit the amount of time they spent with individual patients to the time allotted in the schedule, high-occupational status healthcare providers explained that they felt an obligation to meet the expressed needs of each patient individually rather than follow bureaucratic rules and regulations. In fact, many healthcare providers shared with me that the possibility of spending more time with each patient is what drew many of them to this setting in the first place.

High occupational-status workers’ resistance strategies were seen as creative, albeit frustrating, innovations by CHC’s senior administrative staff and board members, who felt that providing an increased menu of mental health services, especially to Latino

families, was a core component of institutional logics typifying the clinic's ideal role in the community. Simultaneously, these organizational practices stood distinctly at odds with (and decoupled from) institutional logics around bureaucratic efficiency as they were understood at CHC at this point in time. Leaders integrated cognitive structures that categorized undocumented Latinos as an unfairly disenfranchised racially subordinate class, counting them among the "deserving poor," and making sense of complex and contradictory institutional logics in ways that might lead to changes to improve the formally-sanctioned bureaucratic processes surrounding the treatment of this group. In this way, leaders sought to recouple (Hallett 2010) creative resistance efforts with institutional logics from which they were presently decoupled, by integrating workplace cultural structures to more tightly link them with organizational practices with the transcending institutional logic of meeting patients' needs.

Organizational leaders trusted the advice of high-occupational status healthcare workers who were formally credentialed as medical professionals and shared in their communicative interactions (Ocasio, Loewenstein, and Nigam 2014). The bureaucratic legitimation of these workers' perspectives occurred as leaders followed their advice for how best to transform the organizational processes surrounding patient care at CHC to introduce a new, specific set of super-ordinating organizational resources to a formerly subordinate patient population.

Creative resistance occurred as CHC workers struggled to reconcile routinized organizational practices with their divergently integrated cognitive structures surrounding for whom the rules ought to be broken. Not all patients, however, were cast as deserving of extra-organizational social capital resources by these high status actors. In most cases, creative resistance took the form of integrating cultural schemas around the "deserving" poor with racial ideologies that immigrants were unfairly sub-ordinated by a restrictive US welfare safety net system that was designed to motivate "lazy" poor who were otherwise able-bodied to work. Since immigrants were seen as possessing a distinctive "immigrant mentality" valuing hard work, they were deemed a "deserving" patient population and high-status workplace actors made efforts to afford them super-ordinating resources.

#### **3.4.3.3 Collaborative Resistance**

Organizational leaders adopted creative resistance and sought to leverage their social capital resources in ways that met patient needs while mitigating risks associated with precarious bureaucratic structures by entering into "collaborative" resistance partnerships with other organizations. These collaborative resistance efforts included seeking to enter into strategic partnerships with private foundations, publically-available funding mechanisms, and other organizations.

An exemplar case of the conditions preceding the hiring of Samantha illustrates how creative resistance efforts became sanctioned and legitimated through their



transformation into collaborative resistance. The creative resistance efforts in the case of healthcare providers seeking to enhance the scope of CHC's mental health resources afforded to patients (discussed in the "creative resistance" section above) was adopted as collaborative resistance in efforts to meet the particular needs of Latino patients. CHC's executive director explained to me that the organization was able to secure a small county grant which enabled it to partially expand the scope of its mental health counseling resources "to address Spanish-speaking patients' psychiatric needs in a more robust way" by hiring Samantha, a marriage and family therapist who had also received formal training in cross-cultural counseling techniques and is fluent in Spanish.

However, this case also illustrates the precarious and limited scope of impact through CHC's efforts in its wider social and geographical context. Samantha was hired to work part-time at CHC and part-time at another local safety net organization, and quickly found her schedule filled with appointments in which, after extended periods working to gain patients' trust, she was repeatedly asked by undocumented Latinas to help them discern whether to stay in emotionally and physically abusive relationships with their spouses and the fathers of their children.. These Latina mothers knew that they faced a constant threat of deportation, were excluded from the formal labor market, and that their low educational attainment precluded them from accessing many socioeconomic resources. Samantha was well-liked among her co-workers and tears filled her eyes as she described how much she loves working with her patients at CHC.

However, through a chain of events underscoring the contingency of collaborative organizational resistance and the difficulty with which super-ordinating resources can sustainably be provided to disadvantaged groups through formal organizational environments, Samantha left CHC after 13 months for maternity leave, and CHC hired a new part-time counselor to assume her caseload.

Although collaborative resistance efforts were instituted by organizational leaders, not all were successful in transforming CHC's bureaucratic governance structures. One such failed collaboration effort unfolded in the circumstances through which CHC attempted to formally merge with another private safety-net clinic. Merging clinics was estimated by both organizations to be able to reduce overhead costs, reach a wider population than the current maximum patient capacities across the two organizations, and increase the amount of healthcare and health-promoting resources provided to patients. However, this partnership failed and CHC "felt jilted at the altar" by the other organization, in the words of CHC's executive director, because while CHC leaders felt that its institutional logics were fully shared by the other organization, the other clinic's leaders expressed in a joint board of directors meeting that they thought CHC placed too high an emphasis on its "faith-based" institutional logic by having a paid, full-time chaplain on staff.

### **3.4.4 Patient Characteristics**

Patient-level characteristics are likely to impact the relationship between organizational processes and life course consequences. For example, differences in class habitus (e.g., Shim's 2010 notion of "cultural health capital"), structural constraints on health behavior (Cockerham 2010), and levels of healthcare system (dis)trust (Boulware et al. 2016; Musa et al. 2009) may shape patients' likelihood of seeking to utilize preventive healthcare systems. Among CHC patients, characteristics shaping healthcare system usage unique to unauthorized immigrant patients corresponded with their (1) reduced likelihood of reporting domestic violence or workplace health and safety violations to governmental authorities (even those authorities who had no jurisdiction for processing and deporting undocumented immigrants), (2) limited use of public safety net resources for which they were eligible (however scarce these resources were), and (3) increased likelihood of missed healthcare provider appointments in private healthcare safety net organizations.

### **3.4.5 Life Course Consequences of Organizational Responses to Resistance**

Below, I outline the health and mobility outcomes for patients who experienced CHC at times of resistance that emerged in the data. I argue that organizational responses to racial, gender, and class resistance, apart from the workplace outcomes they shaped for individual workers, can produce mechanisms that somewhat dampen the effects of wider, extra-organizational interlocking systems of racial, gender, and class

oppression in the life course experiences of the low-income and under-insured patients who utilized CHC over time. I describe three such mechanisms below. First, I describe how keeping or losing access to CHC—an outcome conferred through “regular” resistance—was highly consequential in the everyday lives of patients and their families in relation to wider processes of cumulative disadvantage. Second, I describe how “creative” and “collaborative” resistance practices, if not formally integrated into the formal bureaucratic governance structures of CHC, meant that some sub-ordinate patients were contingently afforded super-ordinate resources during critical periods which led to radically altered long-term health and socioeconomic mobility trajectories. Third, I describe how re-coupling processes of bureaucratic transformation shaped CHC into a setting that super-ordinate patients reliably experienced as a “framing institution” during sensitive or critical periods, which led to positively altered long-term mental health trajectories.

#### **3.4.5.1 Life Course Consequences of Creative Resistance: Radically Altered Trajectories in Exceptional Circumstances**

Creative resistance occurred as high-status workers leveraged their social capital resources to make exceptions for patients they deemed particularly worthy of care. In some cases, creative resistance powerfully mitigated cumulative health and mobility effects of inequality. Two exemplar cases illustrate this process. The first involves Maria, a Latina mother faced with social hardship. Maria came to her appointment distraught because her husband had recently been picked up by ICE and was being held in a

detention center. Not knowing what to do, she asked her doctor to help her. Her doctor cancelled all of her appointments after learning about these circumstances, and set in motion a chain of events revealing CHC's social capital resources at their best. CHC's executive director and director of development, both licensed attorneys, called their contacts at the courthouse. Within 48 hours, Maria's husband was released. Concerned that the family remained at risk for deportation even after their intervention, they again leveraged their resources to obtain green cards for the family.

The second case involves Rose, another undocumented mother who (along with her husband) was a patient at CHC and was at home with her two young children while her husband worked at a construction site. Rose was shot in the neck during a home invasion and is now paralyzed and quadriplegic. Her husband lost his job because he was needed at home to take care of his disabled wife and the family was in need of resources far beyond the scope of CHC's formal organizational offerings. So, upon hearing this story, CHC's director of development organized a holiday fund drive to benefit this family. Knowing the channels they needed to utilize to advocate for their legalization, CHC's leaders met with the husband and, through an interpreter, explained that their family was now eligible for authorized immigration status due to their victimization in a violent crime. CHC managers worked with this family to again secure green cards, as in the first exemplar case described above.

### **3.4.5.2 Re-Coupling Resistance to Create a “Framing Institution”**

At times, creative and collaborative resistance became routinized in formal changes to bureaucratic routines, either by direct changes to CHC's internal governance structure (through the routinization of creative resistance) or through the adoption of formal cross-organizational partnerships with other safety net organizations (through the routinization of collaborative resistance). The routinization of creative resistance via direct adoption into organizational processes at CHC afforded a more reliable set of patient resources than collaborative efforts, which remained somewhat precarious in their dependence on extra-organizational funding structures, limited in the scope of patient impact due to the sharing of workers across organizations and with multiple sets of client populations, and reliance on the maintenance of goodwill and desire to remain in partnership between administrators leading organizations with distinct sets of institutional logics.

Re-coupling responses to the creative resistance efforts of medical providers who advocated for additional mental health resources to better address patients' unmet mental health needs, for example, diverged between the structure and scope of resources provided to patients along the axis of language. The emergence of a counseling department at CHC was a direct, internal response to the creative resistance work of healthcare providers who refused to adhere to their schedules and instead sought to address emergent mental health needs for each patient individually. However,

the paid staff and key volunteer personnel composing this department only spoke English, so volunteer translators were included in counseling sessions with Spanish-speaking patients.

A collaborative resistance effort emerged in response to medical providers continuing to share with senior CHC administrators that Spanish-speaking patients consistently presented the most acute mental health needs due to their generally lower social class location, formal exclusion from public assistance, and living under constant deportation threat. In response, and described as an exemplar case illustrating collaborative resistance above, CHC eventually hired Samantha through a collaborative effort with another safety net organization and a county-level funding mechanism to work directly with the Spanish-speaking patients who were formerly excluded from the level of intimacy and trust afforded in English-speaking patients' 1-1 counseling sessions through CHC's counseling department. However, Samantha quickly found her three days per week at CHC over-booked. She struggled to negotiate a full caseload and long waiting list of Spanish-speaking patients continually referred to her care. In comparison with the relatively robust and institutionalized counseling resources available to English-speaking patients, the scarce resources afforded through CHC's collaborative hiring of Samantha was at best only moderately impactful in the lives of Spanish-speaking patients.

While regular resistance unfolded on behalf of Black patients to prove consequential across age groups represented among this patient population, creative and collaborative resistance efforts tended to have the strongest effects among patients who experienced critical periods of transition and were then able to experience life course turning points whereby CHC served as a "framing institution." Experiencing CHC as a "framing institution" was not limited to routinized resistance, but also occurred in some extraordinary cases, such as the exemplars of Latino families achieving authorized immigration status described above, radically altered their longer-term health and mobility trajectories by affording them new and increased levels of access to public assistance.

In cases of routinized creative resistance, patients who were not "exceptional" in their need relative to other patients came to see CHC's integrated model of primary care and mental health counseling as a cohesive set of resources that helped them through hardships such as poverty and divorce. Margaret, for example, a white female patient who was 64 years old when I interviewed her, had been an established patient at CHC for a few years. She had entered this setting during her divorce proceedings and after being dropped from her husband's employer-provided health insurance plan. Coincidentally, she also entered CHC immediately after it had expanded its set of mental health services in response to the creative resistance practices of healthcare providers refusing to truncate their visits with patients if it meant that patients left their



appointments with unmet mental health needs (detailed above in the “creative resistance” section). After her first appointment with her primary care physician, Margaret was referred to a staff counselor who, she explained, helped her process through her emotions surrounding her divorce and the long years of emotional abuse that had preceded it.

Even relatively high socially-positioned patients such as Margaret feared losing their status as CHC patients because of the cohesive set of resources it had afforded them at critical life course periods of transition amid social hardships. In her interview, Margaret expressed that before an appointment with her primary care physician earlier that day, she felt fear when she thought of the fact that she was turning 65 in a few months, because this age meant that she would gain access to Medicare and experience a loss of her status as a CHC patient. However, she felt reassured as we spoke about this transition because her doctor had told her that she would be able to come to CHC two more times—once again to discuss finding a Medicare provider who would be a good fit for her needs, and again after a few appointments with her new Medicare provider to check-in on how Margaret was feeling about her new usual source of care. Margaret recounted this conversation smiling, as her eyes welled with tears, “She told me, ‘Look, we’ve invested a lot in you. I personally don’t want to see that go to waste. You know now that you are worthy of high-quality healthcare, and that you deserve to be more than an appointment on somebody’s book. I want to make sure that happens for you,

moving forward." Margaret's case and others like it illustrate how creative resistance practices leading to CHC's expansion of the scope of mental health services facilitated the experience of CHC as a "framing institution."

### **3.5 Discussion**

Overall, findings indicate that the formal governance structure of CHC adapts dynamically over time in response to worker resistance efforts, either through (A) the levying of negative sanctions on workers who act through "regular" resistance that breaks bureaucratic rules for schema-illegitimate reasons, (B) the constructive valuation and routinized appropriation of "creative" resistance work that breaks rules for schema-legitimate reasons to address the unmet needs of patients deemed "deserving," or (C) the appropriation of "collaborative" external resistance work that facilitates organizational change during critical temporal periods. Through their valuation as legitimate strategies of action, "creative" and "collaborative" resistance become bureaucratically appropriated and formally adopted to shape successive iterations of the organization's institutional viability and menu of patient services. In the case of (B), the organization's responses to creative internal resistance, the causes and consequences of resistance are not only patterned by the routinized practices of a bureaucratic organization, but also *pattern* the bureaucracy itself in a dynamic, iterative process over time through which the structural disadvantages perceived in unusual and adverse life course circumstances encountered by patients provide a vehicle for rapid, powerful, and

constructive organizational change.

### **3.5.1 Precarious organizations and organizational change in a New Immigrant Destination**

Organizational bureaucracies are not static features of a racialized social system but adapt over time to changing organizational resource environments and dynamic gendered racialization characterizing the "places" within which they are embedded. This resonates with Ray's (2017) theory of racialized bureaucracies, which treats racialization as a dynamic and ongoing process by which workers and clients are situated and re-situated as subordinate or superordinate groups through integrating ideological and schematic structures (Sewell 1992), and upon whom material resources are conferred through successive iterations of formal structures governing organizational processes.

Organizations' responses to workers who act to resist racial ideologies reified in what they perceive to be outmoded bureaucratic governance structures decoupled from concerns for patient care underscore theories of the ambiguous and dynamic positioning of Latinos with respect to Black and White Americans. Resistance on behalf of Black patients was met with punitive sanction at CHC, as the schema of the "deserving poor" did not successfully intersect with racial ideologies rooted in structure rather than culture in the cognitive structures (Sewell 1992) held by high-status organizational administrators who hold the power to legitimate resistance through routinization. Resistance on behalf of Latinos, however, was undertaken by higher-status organizational actors at CHC who sought to address their unmet needs by integrating

cognitive structures of racial ideologies (which situate Latinos as structurally disadvantaged) and cultural schemas of those with strong work ethics as constituting the "deserving poor." Formal governmental mechanisms of exclusion were at times viewed by powerful actors within CHC as reifications of wrongheaded subordinating racial ideologies; these actors sought to confer some super-ordinating resources upon Latinos when cultural schemas of "deservingness" were successfully integrated with other features of workplace culture. This re-affirms notions that racial ideologies may be descriptive cognitive explanations for extant inequality applied to justify the superordinate position of Whites, the intermediate racial strata of "honorary Whites," and the subordinate position of "collective Blacks" (Bonilla-Silva 2004). It also advances social scientific understandings of how Latinos may be situated temporarily as "honorary Whites" in NID settings and during periods of restrictive immigration policy regimes (Mueller and Bartlett 2017).

### **3.5.2 Safety net usage as a life course "event"**

Structurally gendered and racialized features of private healthcare safety net organizational processes confer disparities in health and socioeconomic mobility trajectories among under-employed and under-insured patients and differentially shape the likelihood of patients experiencing these settings as vehicles for improved long-term health and mobility trajectories during critical life course transitions. This resonates with understandings of safety net bureaucracies as "framing institutions" that operate as life

course turning points to partially mitigate the cumulative disadvantage processes of interlocking systems of racial, gendered, and class-based oppression (Watkins-Hayes, Pittman-Gay, and Beaman 2012; Watkins-Hayes 2013).

Simultaneously, this conceptual model raises questions for future research to explore. For example, Black patients at times receive super-ordinating resources through workers' practices of "regular resistance," but these behaviors encounter constant punitive sanctions by a dominant white racial organizational culture. Although consequential in moderating the life course effects of cumulative disadvantage, regular resistance is neither a reliable nor widespread organizational practice. At times, Latinos receive super-ordinating resources through private healthcare safety net organizations which enable better health and enhanced mobility, but overall, this resource environment is more precarious for them—even in the face of their overall lower social class position—than for English-speaking populations. Although racial resistance was not observed to be practiced on behalf of whites, they nonetheless benefit from organizational transformation as the super-ordinate racial class of patients at CHC. Overall, English-speaking patients are more likely to experience the private healthcare safety net as a "framing institution," as their relatively higher social class status and ability to speak the language of the dominant culture corresponds with elevated levels of access to formal organizational processes that arise from routinized practices of resistance.

Specific themes for future research to explore include analyzing whether and how these organizational processes differ in bureaucratic settings with differently-racialized occupational strata such as Community Health Centers, which are formally required to include patients as 51% of their board of directors. Another fruitful area for future research lies in exploring differences between NID settings and in established immigrant destinations where different sets of racial ideologies and cultural schemas might be applied to Latino patients. Future research should also seek to address whether and how broader contextual features characterizing safety net institutional fields shape racial resistance and organizational change, for example by comparing settings in states with expanded Medicaid coverage to other settings within which Medicaid was not expanded and a larger health insurance coverage gap persists.

## **4 Unauthorized, Uninsured, and Undeterred: Latina Mothers' Strategies for Combatting Cumulative Health Disadvantage**

### **4.1 Abstract**

What role does the healthcare safety net play in the efforts of unauthorized Latina immigrant mothers to mitigate uncertainty and cumulative health disadvantage? Guided by insights from research on cumulative health disadvantage, coping, and resilience, this study explores how unauthorized Latina immigrant mothers understand primary healthcare usage amid everyday lives marked by poverty, trauma, hardships, and resource scarcity. Data include interviews with 32 unauthorized Latina mothers conducted in 2016 in a mid-sized urban southeastern U.S. setting which has become a New Immigrant Destination. Findings indicate that respondents strategically avoided, used, and leveraged resources contained in healthcare systems. They found social support resources and took on coping strategies in order to enhance their abilities to better advocate for their families. The implications of these patterns for healthcare policy and future research are discussed.

Key Words: cumulative health disadvantage, unauthorized immigration, gender, social support, healthcare usage

## **4.2 Introduction**

This study situates unauthorized immigrant Latina mothers' strategies for using safety-net primary health care resources in the broader context of their experiences of trauma, everyday social hardships, and hopes for the future. This study links cross-sectional interview data highlighting the subjective perspectives of individuals to theories of longitudinal cumulative health disadvantage processes in the extant empirical literature. This investigation answers two calls for research, one explicit and one implicit. First, Hitlin and Johnson (2015) have recently appealed for social scientists to renew attention to the role of multidimensional, subjectively experienced human agency in temporally-situated sequences of life course events. Second, this study is an effort to respond to the implicit urging by the mothers featured in this study. They draw attention not only to stated desires to receive healthcare treatment but also to the contextual factors—sometimes within and sometimes outside of their control—that powerfully shape whether and how they access healthcare systems.

By carefully attending to the ways the mothers in this study relate their life course experiences that surround particular courses-of-action, I aim to contribute to sociological theories of healthcare usage and cumulative health disadvantage. This study includes findings from an analysis of qualitative data on 32 low-income unauthorized immigrant mothers residing in a southeastern urban environment which has recently become a New Immigrant Destination. Analysis was conducted to examine



these respondents' approaches toward healthcare and welfare resource utilization amid everyday social hardships, resource scarcity, and sources of hope for the future.

Emergent findings from these interviews indicate that multidimensional approaches to understanding healthcare system usage which incorporate traumatic life events, everyday hardships, social support, and religious coping may more fully illuminate the cumulative health disadvantage experiences among unauthorized immigrant families.

### **4.3 Background**

#### **4.3.1 Theorizing immigration policy and cumulative health disadvantage**

A wide body of research documents the cumulative health effects of inequality across the life course (O'Rand 1996; Dannefer 2003; Willson and Shuey 2007; Brown and O'Rand 2012). Group-level differences in health grow with age, as superordinate groups experience the accumulating effects of social advantage while subordinate groups experience the compounding effects of long-term exposure to adversity. U.S. racial and ethnic disparities in health, for example, tend to be narrower at younger ages and wider at older ages as the effects of living in a social system structured by racial inequality unfold over long periods of time (Gee and Ford 2011; Viruell-Fuentez, Miranda, and Abdulrahim 2012).

Recent research has explored the role of temporal changes in the U.S. context as a source of cumulative health disparity (Rhodes et al. 2015; Viruell-Fuentes et al. 2012). Policy changes not only structure the composition of migrant cohorts (Garip 2017) but

also shape access to Medicare, Medicaid, Supplemental Security Income, and health services that mitigate the accumulation of health problems as individuals age (Martinez et al. 2015; O’Neil and Tienda 2015). Migration scholars have theorized that both the composition of migrant cohorts and their exposure to conditions in receiving contexts are shaped by immigration policy regimes (IPRs), or broad sets of social structures organizing the racialization and incorporation experiences of immigrants in terms of their possibilities for citizenship, work, and participation in everyday economic, cultural, and political life (Faist 1995; Sainsbury 2006). Exposure to more-restrictive IPRs, for example, is associated with health disadvantage decades later among Mexican American immigrants (Mueller and Bartlett 2017). The present “post-IRCA” IPR, following the passage of the Immigration Reform and Control Act in 1986, is characterized by increased levels of border enforcement and increasingly precarious labor market conditions and threat of deportation which have been exacerbated in more recent years with the increasing criminalization of unauthorized immigrants (Durand et al. 2016; Martinez et al. 2015; Hartry 2012).

Unauthorized immigration status has been usefully conceptualized as a racialized legal status (Asad and Clair 2016), theorized to shape disparities through primary effects on unauthorized immigrants and spillover effects on their U.S.-born children. Unauthorized immigration status restricts access to publically-available health-promoting resources such as Medicaid, Medicare, and TANF which immigrants may

otherwise utilize to mitigate functional health declines (Hagan, Rodriguez, Capps, and Kabiri 2003; Marrow and Joseph 2015). Formal and informal means of immigrant incorporation under U.S. IPRs are also stratified by class and gender. For example, researchers document gender differences in disability among older Mexican Americans (Hayward et al. 2014) and theorize that health-promoting resources are unequally distributed to the disadvantage of women (Brown and Hargrove 2013; Viruell-Fuentes et al. 2012; Mueller and Bartlett 2017).

#### **4.3.2 Safety net usage as a life course “event”**

A wide body of sociological research documents enduring links between social conditions and health inequality (e.g., Link and Phelan 1995; Braveman and Gottlieb 2014). Life course scholars have extensively investigated the “long arm” of social conditions experienced during critical periods earlier in the life course on health and mobility outcomes decades later (Elder and Rockwell 1979; Elder 1994; Hayward and Gorman 2004; O’Rand and Hamil-Luker 2005). For example, Umberson, Williams, Thomas, Liu, and Thomeer (2014) develop the concept of “chains of disadvantage” in their investigation of the link between relationship quality and health disparities between Black and White adults. They find that exposure to childhood adversity contributes to health disparities in part through its enduring influence on relationship strain in adulthood, especially among men. Interestingly, experiencing stress in adulthood plays an even greater role than childhood misfortune in explaining racial

disparities in health among women (Umberson et al. 2014). These findings underscore the need for researchers and policymakers to better understand the distinct pathways through which stress proliferation and social support contribute to racial/ethnic health disparities and may differ for women and men (Harrell 2000; Perry, Harp, and Oser 2013).

Encounters of safety-net healthcare organizations unfold during particularly sensitive life course periods marked by the subjective experience of exacerbated social and economic uncertainty through within-person changes of job loss, divorce, and/or the onset of health catastrophe. Rank and Hirschl (2002) have helpfully conceptualized safety net usage as a widespread short-term life course “event” among Americans. They suggest that “contrary to conventional wisdom, the use of the United States social safety net is a mainstream experience” (Rank and Hirschl 2002:238). They estimate that 65% of Americans will use welfare at some point by the time they turn 65 years old, but fewer than sixteen percent will do so for over five consecutive years.

Interacting with safety net organizations over time during sensitive life course periods can powerfully alter long-term trajectories and potentially mitigate the cumulative effects of social disadvantage by providing an institutional setting for social support, trust, and enhanced resource provision. Watkins-Hayes, Pittman-Gay, and Beaman (2012), for example, find that safety net workers can function as “key framing agents” who facilitate the transformation of subjectively-experienced illness conditions

and enhance resilience. Vargas (2016) also investigates the work of safety-net healthcare workers, and finds that patient navigators achieved success when they built trust and patients believed that they held their best interests at heart amid a social backdrop of structural disadvantage. Konczal and Varga (2011) find that unauthorized immigrants often avoided primary care, even when it was offered freely, due to forms of structural and symbolic violence including confusion about bureaucratic eligibility requirements, deportation fears, and the possibility of unexpected additional bills. Konczal and Varga interview safety-net healthcare workers and find that these individuals sometimes serve as “compassionate compatriots” who calm these anxieties and guide immigrants through the health care system.

It is particularly important for health researchers to understand dynamics linking the receipt of social support in particular institutional environments to the biographical experiences of unauthorized Latina mothers. Researchers have begun to explore processes highly relevant to this domain. Finch and Vega (2003), for example, found that social support and reliance on religious support resources buffered some of the adverse effects of legal status threat on self-rated health. Investigating unauthorized immigrants’ strategies for using safety-net health resources provides an opportunity to conceptualize healthcare access and usage in the context of individuals’ everyday lives. Doing so may help to clarify the linkages between cognitions, behaviors, experiences of discrimination, and structural disadvantage among unauthorized Latinos, theorized to contribute to

growing disparities in healthcare usage between aging Latinos and non-Hispanic whites (Mahmoudi and Jensen 2013).

A wide and growing body of poverty research documents the importance of understanding behaviors of the poor in the context of their everyday experiences of uncertainty (Silva 2013; Garrett-Peters and Burton 2015). Garrett-Peters and Burton define uncertainty as “a state of ambiguity, one in which immediate and future conditions or events are unpredictable or otherwise not clearly determinable by the actors involved” (2015: 246). They theorize that chronic uncertainty in low-income environments can lead to a lower probability of engaging in behaviors that are more likely to lead to better conditions for individuals and their families. “Poor mothers,” Garrett-Peters and Burton argue, “may often act with an eye toward the moment rather than the long run, as unpredictable resources and the ever-present specter of need require orientation to the here and now” (2015:246). Situating healthcare usage in the context of the uncertain conditions marking low-income unauthorized Latina immigrant mothers’ everyday lives can help to clarify the role of stressors and coping and provide a new set of conceptual tools for future researchers to draw on as they seek to shed light on processes that reflect the unique experiences of disadvantaged groups (following Brown and Hargrove 2017).

## **4.4 Data and Methods**

### **4.4.1 Overview of the study**

To investigate mothers' strategies for using safety-net primary care resources in relation to their efforts to traverse life course processes that accumulate disadvantage, I analyzed qualitative data on undocumented Latina immigrant mothers who participated in a team-based ethnographic study conducted by the author. This research project was a longitudinal and multimethod project designed to examine how the everyday experiences of low-income and uninsured adults shape both the healthcare and welfare resources they have access to and the ways in which they navigate private safety-net healthcare organizations in the years following the passage of the Affordable Care Act. Study participants resided in a mid-sized city in the southeastern U.S. which has become a New Immigrant Destination. Primary data collected in this study included ethnographic observations and informal interviews of healthcare safety-net workers, patients, and their families, and audio-recorded in-depth interviews with Black, Latino, and non-Hispanic White male and female uninsured patients purposively sampled to understand heterogeneity in life course experiences and cognitive approaches toward the role of a private healthcare safety net setting in patients' everyday lives.

### **4.4.2 Recruitment and sample description**

Patient interview respondents were recruited into the study and interviewed between May and July 2016. Recruitment occurred through face-to-face interactions

between ethnographers and potential respondents in the waiting room at Compassion Health Clinic, a private primary care safety net clinic. At the time of enrollment, all 32 Latina mothers who participated in this study had household incomes below 100 percent of the federal poverty line; reported unauthorized immigration documentation status; were not covered by Medicaid, Medicare, or private insurance; had two or more children; had less than high school education; and ranged in age from 23 to 86 years old. 15 were married or cohabitating with a partner, 13 were separated or divorced, 2 were single, and 2 were widowed. 21 reported experiencing intimate partner violence, and 29 had been diagnosed with multiple co-occurring chronic physical illnesses (most commonly diabetes mellitus, hypertension, and conditions under the umbrella of chronic obstructive pulmonary disease).

#### **4.4.3 Data sources, coding, and analysis**

Data sources include two types of interviews conducted with respondents. First, semi-structured, in-depth interviews with 21 respondents were audio-recorded, transcribed, and translated by Spanish-speaking members of the team of ethnographers. Second, informal ethnographic interviews with an additional 11 respondents also contained sufficient data for inclusion in this study. Interviews and ethnographic field notes were coded collaboratively in team data analysis (TDA) sessions. TDA sessions involved ethnographers' (1) identifying and interpreting salient themes that emerged in



each interview case and clinic day before subsequently (2) identifying connections, similarities, and differences across cases and (3) finding group-level patterns.

Three phases of modified grounded theory coding on complete sets of data for each case were conducted in this analysis, following Burton's (2014) method of applying modified inductive techniques to relate extant scholarly insights to emergent themes in qualitative data. First, field notes, interviews, and recordings of TDA sessions were open coded with common codes and sensitizing concepts around health, healthcare usage, access to welfare safety-net resources, coping strategies, and social support (Glaser 1978). Second, a method of "constant comparison" (following Huberman and Miles 1994) was conducted, during which axial coding was employed within and across cases. Codes were cross-checked with insights derived from case- and group-level comparisons that emerged from TDA sessions. In this phase, I identified distinct patterns in (1) temporally-situated biographical experiences of trauma, social isolation, and social support and (2) cognitive strategies for linking healthcare system usage to hopes for family well-being. Finally, I employed selective coding to reveal the key thread, or "storyline" of this analysis (following LaRossa 2005). I present this narrative below by bringing representative "exemplar cases" (Abbot 1992) to illustrate patterns that emerged from the data (following Burton 2014).

## **4.5 Findings**

Immigrant mothers saw their healthcare-seeking behaviors as one component of their strategies to deal with hardships faced in everyday life and care for their children. Findings are presented in two sections below detailing how respondents (1) cope with life course trauma and everyday hardships, and (2) navigate, ration, and sacrifice resources to secure family well-being.

### **4.5.1 Remembering life course trauma and everyday hardships**

Most respondents described experiencing traumatic events in at least one of three temporal periods in their individual biographies, characterized by: (1) feeling forced to abandon children with extended family members in their countries of origin before migration (17 respondents); (2) surviving for days without food or water and enduring physical injury while migrating (6 respondents); and/or (3) subjection to physical and/or emotional intimate partner violence while residing in the U.S. (14 respondents).

Seventeen respondents reported feeling that they were forced to leave one or more children behind in their countries of origin. None who reported leaving a child “behind,” in the words of one mother, wished to come to the U.S., but felt forced to do so due to circumstances beyond their control. All respondents who mentioned this experience did so through tears and downcast gazes, even in cases when many years have passed and their children are now adults with healthy families of their own.

Esperanza, for example, began weeping as she described her feelings of helplessness about leaving her young daughter with members of her extended family in another Central American town as she fled a drug cartel which had threatened her life and the lives of her family twenty years ago because, she speculated, “they felt I had certain information...and they were scared I was going to tell someone the information that I knew.” “Those people,” Esperanza recalled, “are the type of people that they...won't just harm one person, they'll harm the whole family.” Esperanza remains filled with feelings of failure and regret as she recalls the conditions surrounding her immigration to the U.S. even as she expresses thankfulness for her extended family members’ efforts to raise her daughter and a swelling sense of pride and joy that her daughter has secured employment and recently gave birth to a new child of her own.

Esperanza’s hardships did not cease as she crossed into the U.S. without documentation, guided by a *coyote* who she and her partner had entrusted with most of her life’s savings. She described taking multiple stops before finally reaching the southeastern city in which she currently resides, including briefly living in the Southwest before her partner decided that they should break up and she ought to move away rather than live in the same city as he and his spouse (of whom Esperanza was unaware until her arrival into the U.S.). Nor was Esperanza alone in experiencing hardships in her border crossing. Five other respondents reported enduring physical health problems during their migration journey. These challenges included walking

through the desert for weeks at a time with no knowledge of location, anticipated duration of the journey, or whether food and/or water might be available tomorrow or not until four days from now. One respondent reported losing some toenails due to the strenuous journey, while others reported the onset of conditions including chronic back pain and difficulty walking for which they are currently seeking healthcare treatment.

Seven respondents reported that they could not recall the conditions surrounding their migration to the U.S. Each of these respondents expressed their inability to remember while sharing a look of concern with their interviewer or a marked shift in tone from enthusiastic engagement to hushed sadness coupled with a sense of detachment, captured in audio recordings. The team of ethnographers interpreted these reports of not remembering in light of body language and verbal cues as indicating possible repressed memories, a desire to shelter the interviewer (who was in many cases was close in age to the respondents' oldest child) from sensitive traumatic events or their unprocessed emotions of fear or anxiety, or a wish not to relive troubling past experiences (Bookbinder and Brainerd 2016). It is also plausible, however, that the respondents who reported that they could not recall the conditions surrounding their migration may not have experienced this journey as a particularly salient moment of uncertainty that stood out from the broader array of their everyday experiences with hardship; or they may have traveled under more favorable circumstances and simply forgotten.

All 32 respondents reported everyday hardships of precarious employment conditions, reported transportation barriers (including mentions of relying on their husbands or ex-husbands as their sole source of transportation), and 27 reported perceptions of discrimination in healthcare treatment. Experiences of life course trauma and everyday hardships helped place healthcare seeking behaviors in perspective as one component of their broader strategies to mitigate uncertainty.

#### **4.5.2 Navigating, rationing, and sacrificing resources to secure family well-being**

Respondents consistently shared that they felt they knew when and how to use CHC versus other clinics, as in the words of one respondent, “It’s cheaper here, but it’s worse here than the other place.” Patient knowledge of prescription costs, eligibility criteria, appointment co-pays, and availability of resources across a fragmented safety net were critically important features of the stories all interview respondents shared. They were especially salient for the five mothers who reported having unauthorized immigrant children who are simultaneously excluded from Medicaid and most private safety net clinics (which tend to only see patients 18 or older).

Isabella shared that although she had not received any formal schooling and does not receive food stamps, she indicates that her family of five does not typically struggle with finances even though they live on approximately \$14,000 per year.

“Me and my husband...we never had trouble paying our bills. We don’t have food stamps, just Medicaid for the two children who were born

here...my undocumented son who is 14 does not get Medicaid because he is undocumented, and they can't see him here [at CHC] because he is underage. When I take him to the dentist, it's pretty expensive."

Isabelle used to go to a nearby community health center, and then her doctor there told her that she could receive the same treatment at CHC for less money.

Isabelle shared that she knows which clinics are better than others, but

"sometimes the worse clinics are better because they are cheaper out of pocket."

Isabelle shared that she was afraid that not being able to pay her bills would lead to the government finding out and subsequently deporting her, her unauthorized husband, and her unauthorized son, leaving her two younger U.S.-born children abandoned with no one to care for them.

Isabelle's experiences resonated with those of Marisol, who revealed that she comes to CHC for most of her primary care needs but goes to another clinic when she knows her symptoms require medications that CHC does not have available for free or at a reduced cost. Marisol also mentioned that while she goes to multiple organizations to meet her primary care needs, she only brings her father, in his late 80s, to one more expensive clinic because "he has a lot of health issues" and this setting provides some of his prescriptions for free. She shared that she spends over \$140 each month for her family's prescriptions.

Some respondents discussed how they made hard health choices and took on risks to protect their family members from exposure to adversity. Respondents saw some resources as more important and worthy of sacrifice than others. For all 32 respondents, medications could be rationed: bills needed to be paid out of fear of legal sanction and deportation, and stretched budgets left little or no money for prescription adherence as directed.

Esperanza took two years off from her work cleaning houses to care for her husband after his workplace injury and visited her country of origin three years ago to care for her sick mother. Although her ex-husband was physically and verbally abusive, she tries to stay on good terms with him because doing so means she is able to access some financial resources for her blood pressure and diabetes medications: "I have to be on good terms so I get money for my medications."

Esperanza mentioned that she does not like coming to CHC because sometimes the people she talks to seem like they are discriminating against her. For example, one of the times she called to change an appointment, the person who answered her did not know how to help her. She recounted their conversation:

Esperanza: "Let me talk to someone who can actually fix this."

Worker: "No because they speak English and you don't."

E: "Just pass me the phone!"

W: "No, you don't speak English, *blah blah blah*."

E: "No, I *can* speak English to a certain degree, I understand it, so I'm willing to find a way to tell them!"

Esperanza revealed that there were two occasions in which she found herself yelling with her interpreter, who she felt did not really want to help her but only saw it as a job: "it's their job, they get paid for this, and it seems like they don't want to do it." She said that sometimes the people at the reception desk are "pretty rude, and they don't really help people who speak Spanish as much. And also when it comes to getting [a patient eligibility] card and having to renew it every year, they're not being very helpful with that, like when people I've recommended come in." Still, Esperanza believes CHC is worth her and her friends' time because "the medical team is amazing except for the interpreters or whatever and the reception desks."

#### **4.5.3 Coping with adversity and hoping for the future**

Respondents also reported a variety of coping strategies for dealing with adversities that they used to minimize their children's exposure to their own hardships, such as social support provided by other family member(s) (12 respondents), close friend(s) (7 respondents) or through conversations with a mental healthcare professional (8 respondents). Only 2 women mentioned discussing important matters with their partners, while 4 suggested that they feel most comfortable only talking to God because, in the words of one respondent, "Walls can hear you but they don't talk. People gossip and God listens." Identifying these varied approaches to understanding close



relationships as a possible means to facilitate (or alternatively, to hinder) coping aided my discovery of the ways respondents approached coping resources dynamically over time. Some respondents disclosed that they preferred not to talk to clinical professionals about their problems, while others stated that they slowly developed trust for available counselors present at CHC.

One mother, after disclosing that she had experienced child abuse in her country of origin and domestic violence more recently in the U.S., was asked how she coped with these adversities. She explained that she found prayer and attending her Catholic parish a source of strength, paraphrasing a Bible story about God remaining with her even though other people would come and go in and out of her life. Another woman also stated that she does not trust people but that she talks to God frequently. She worries about her own future but hopes that her daughter will not need to work at a local fast food restaurant as she does, instead achieving her dream of becoming a physician who helps people with Down's syndrome.

Another woman revealed that she enjoyed praying with a volunteer counselor whenever she came to CHC, but then that person left and now she does not talk to anyone here about topics other than her physical health symptoms. Three others indicated that they desired to limit the sharing of their personal information with CHC, repeatedly asking for assurance that their interview would remain confidential before sharing information on their immigration status and indicating that they did not want

the clinic to know anything about them beyond their physical symptoms that needed immediate medical treatment.

Other respondents shared that at first, they had been reticent to disclose personal information with the clinic but came to trust its workers over time and found strength in counseling treatments. Building trust in the organization over time was associated with some mothers' usage of supplemental health resources. They found social support in health education classes which provided a setting for women to gather together in the parking lot for longer than the health education classes they attended to tell stories and share laughter together before returning to hostile and uncertain home environments. Through conversations with other women and with mental healthcare professionals, respondents felt less socially isolated, discerned when to stay in home environments characterized by intimate partner violence and when to exit abuse only to take on increased personal financial hardships and challenges for their children, and passed on knowledge about where to access health and welfare resources for their children.

Maria shared about how she came to trust CHC over time to help her with social hardships. She moved to the U.S. in 2007 with her husband and their young daughter. After a few years, she became pregnant with their second child, but her relationship with her husband had started to get worse and he had started to hit her and not come home some nights. She wanted to leave him, but felt trapped because their family of four had to live off approximately \$9,000 per year and she did not know how she could

get a job with her third-grade education and no ability to speak English. Two years after her second child was born, Maria became pregnant again. Once she found out she was pregnant, she confided:

“I had an abortion at home, and then I had a hemorrhage after that. I started bleeding a lot, and I called the neighbor and she said to go to the hospital. But I didn’t go because I was worried they were going to charge me a lot of money, so I waited until the next day and then went to [a nearby community health center].

Shortly after this visit to the community health center, Maria’s neighbor told her she needs to start taking better care of herself if she wants her children “to have a good life.” Maria indicated that she then heard from another friend about CHC, and now she comes here for her chronic pain and issues associated with physical mobility.

Maria revealed that this clinic became like a home for her when her doctor offered to pray with her, a service she now requests at the end of each primary care appointment. She also meets with Samantha, a mental health counselor, every two weeks to discuss her problems. Since starting to meet with Samantha and discussing her difficult home life, Maria felt empowered to leave her abusive husband and take her two children with her to live at her brother and sister-in-law’s house. Maria said that it is important for her to continue to see Samantha for her social anxiety:

“I talk to my counselor about how I’m nervous all the time...I eat my nails a lot and I’m very nervous and impatient...I’m nervous and anxious about how to leave conversations when I don’t want to talk to people anymore and don’t know how.”

Usually, Maria leaves her children with a babysitter when she comes to CHC, but this time she brought them with her because she did not have a babysitter as a result of forgetting her appointment. When Samantha called and reminded her about her appointment, she assured Maria that it was ok to bring her children with her.

Building trust over time with certain workers was a common theme among respondents and resonates with research documenting the importance of “key framing agents” in mitigating adversity in the life course experiences of disadvantaged populations (Watkins-Hayes, Pittman-Gay, and Beaman 2012). One respondent said that she did not want to talk to a counselor, but her doctor recommended it so she gave it a chance. She now sees a counselor regularly and has come to view her over time as a trustworthy resource for social support and a “vent” to help her avoid placing emotional burdens onto her children.

Over time, interactions with counselors and other healthcare workers who respondents see as providing positive social support facilitate the means by which they come to understand salient features of their unmet health needs, social hardships, and stigmatized identities in relation to an expanded view of the material and emotional

resources available to them in particular safety-net organizations. For some women, organizational trust is built through repeated interactions with these positive framing agents. They come to view their everyday hardships with a renewed sense of hope and agency in, for example, conversations in which they feel they are supported and their lives less uncertain in their ability to choose whether to stay in an abusive partner relationship or leave it and risk additional financial hardships. Simultaneously, they also learn about and come to use a wider array of supplemental health resources (such as fitness classes, fresh produce, and health behavior classes) over time, often spending more time building ties with other patients in the parking lot before and after classes than the amount of time spent participating in the scheduled event which was the ostensible reason for their visits. They swap stories from their lives “back home” with each other, discuss their current concerns for their children and frustrations with their schools, transmit knowledge about the availability of local welfare and health resources for their families, and subsequently recommend CHC to others in their extended kinship networks.

Temporal processes of exposure to CHC do not always lead to increased levels of trust and receipt of social support. While most respondents indicated that they gradually came to trust workers at CHC as they received social support from them, a few respondents said that their distrust was not challenged over time. They perceived that they were the victims of discrimination at CHC, which may have led them to be

more resistant to avail themselves of counseling resources and other means of social support at CHC. Instead, they seek to limit their interactions with CHC to the scope of physical health appointments, prescription refills, and low-cost referrals for specialty medical care and avoid sets of no-cost supplemental health resources. These respondents also commonly mentioned recommending their extended kin stay away from this setting.

Respondents share stories underscoring notions that the accumulating effects of social disadvantage result in direct barriers to accessing medical treatment. Esperanza finds herself using additional counseling and medical resources at CHC these days, although she is unable to use the clinic's supplemental resources and still finds herself frustrated at the interpreters and workers at the front desk. A few years ago, she needed to go to the emergency department for eye problems associated with complications from her diabetes mellitus. She stayed in the hospital for a week, confused and scared for her health, and expressed anger as she remembered that her (now former) husband dropped her off: "He just left me. I expected him to stay with me, the same for me as I did for him for two years when he got into an accident."

After being abandoned at this hospital visit, Esperanza decided it was finally time to leave her abusive husband. She moved with her four children into a place of their own. She continued to walk to a daycare where she worked as a cleaner, and while at work, one of her co-workers saw her injecting insulin. She remembers, "The guy

thought that I was drugging, so he told the manager, the person in charge, and I had to lose the job. I even showed them the prescription!" Now out of work, she started rationing her insulin medication to feed her children. She then experienced a hemorrhage in her leg, which was treated through another stint at the hospital. Now, she shares:

"I used to [participate in a mobility exercise class] here but now I don't because I don't have a way of transportation...it was a forty minute walk to the clinic...I used to clean houses and to get to each house I would sometimes walk up to eight miles...I used to walk all the time, but now with my leg I can't get here because my only way to get around is walking and my husband, who is no longer my husband...sometimes when I come here I get a taxi but that's \$10 to come and go and then plus the \$20 they charge me, so it's \$40 each time, and that's pretty expensive."

Esperanza explained that she cannot secure employment because every time she applies for one, "they notice the leg and it's a disability and they don't give me the job. You know, I constantly tell them you know...I'm using my hands, not my-- it's not a problem, or whatever, but they look at my leg and they don't want to hire me. So I don't have a job right now." Esperanza sometimes finds herself debating whether to procure treatment for her leg pain or for her diabetes:

"It got to a point where I get this one or I get this one...you know, I need to start going to physical therapy for my leg but it's pretty expensive and right now I don't have any other means of income coming in except that my kids' dad is giving me money but for them—for rent, for food, for bills and stuff—and even like that, sometimes he takes a while to give me money so that they can pay the house bills or whatever, and I have to be ok, I have to be on good terms with him so that he can give me money for medications."

To "be ok" and to "be on good terms with him," Esperanza shared, "I talk to God a lot...and a *bolia* here [at CHC] who is a counselor." She explained that she was grateful for this counselor who "helps me not to have to depend on my daughter, because I don't want to burden her."

All respondents indicated that their unauthorized status was challenging for their everyday lives. For example, in the words of one mother: "not being documented is hard because I don't have access to any government help, but I still work hard and pay everything on time...me and my husband are scared of being deported." She shares important matters with her sons and aunt and did not mention discussing her fears with her husband.

While approximately half of the respondents felt wary of CHC knowing that they were unauthorized immigrants, the other half expressed indifference about



whether or not CHC knew their status. In the words of one woman, “It’s not that bad, most of us are illegals...I don’t care who knows about me not having papers.” These respondents were sometimes so frustrated with the unfair treatment their families faced in society that they expressed anger and demanded attention to their legal status in efforts to inspire workers at CHC to act fairly. Julisha, for example, shared that she called on the clinic to “put your money where your mouth is” when she came to an appointment a day after her husband was picked up by Immigrations and Customs Enforcement agents and subsequently held in a detention center. She shared with her doctor that she feared he would be deported, leaving her alone with their three small children with no financial support.

Julisha’s doctor responded by cancelling the rest of her appointments for the day and calling an emergency meeting with the senior administrative staff at CHC, including two licensed attorneys. Julisha’s doctor testified in court on behalf of her husband, and the lawyers on CHC’s administrative staff found a way to re-classify the family’s status as legal due to their receiving death threats in their country of origin immediately before their moving to the U.S. While others did not understand or experience CHC as powerfully as Julisha in terms of its ability to mitigate their experiences of social disadvantage, each mother in the sample saw herself as strategically using healthcare resources to mitigate uncertainty and interacting with organizations in ways that protect her family from adversity.

## **4.6 Discussion**

### **4.6.1 Healthcare usage and cumulative disadvantage processes**

In this study, cross-sectional interview data were analyzed to better understand the relationships between sequences of adverse life course events and healthcare usage. Deep links between border-crossing narratives, everyday hardships and trauma, and coping strategies captured in these interviews resonate with other research indicating that the social conditions preceding, during, and after entrance into the U.S. may operate as an important sequence of life course events (see for example Dreby 2015; Reid 2012; Mueller and Bartlett 2017; Garip 2017; Viruell-Fuentes, Miranda, and Abdulrahim 2012). In this study, strategies for using healthcare organizations during periods of salient deportation threat were closely tied to respondents' perceived social support received through interactions with healthcare workers.

Respondents' varied experiences of perceived social support offered through healthcare workers over time corresponded with whether and to what extent they saw CHC as offering resources that may mitigate deportation threat and/or the everyday experience of social hardship. Some women in this study sought to limit the knowledge that CHC had about their unauthorized documentation status and sought to shield themselves and their children from exposure to formal organizations to reduce deportation threat, cautiously and carefully using select healthcare resources while positioning this organization as a potential source of additional adversity.

Others described gaining trust in the provision of social support at CHC over time. Their repeated interactions with particular workers corresponded not only with their continued usage of CHC for primary care services as they faced accumulating adversities and during a time marked by high levels of deportation threat, but also expanded their exposure to resources at CHC beyond the singular domain of primary care. Rather than viewing exposure to all healthcare bureaucracies as a potential risk factor to be avoided, their cognitions and levels of trust changed as they gradually came to understand CHC as a potentially powerful tool to help them mitigate the effects of trauma and hardships in everyday life and sought to leverage CHC's formal and informal resources to halt processes of deportation, gain authorized immigration statuses on behalf of their families, and otherwise mitigate cumulative disadvantage processes in their lives to benefit their children's life chances.

These findings suggest that there may be conditions under which periods of deportation threat do not lead to avoidance of healthcare settings. Future research is therefore warranted to more closely examine far-reaching health effects of psychosocial stressors and coping strategies which may be unique to disadvantaged groups (in line with Brown and Hargrove 2017).

#### **4.6.2 Multidimensionality in healthcare seeking strategies**

In light of this study's findings documenting the existence of complex strategies for using multiple primary healthcare organizations simultaneously and selectively

while ascribing varying degrees of (dis)trust to different sets of individuals within and across these multiple organizational domains, health disparities researchers may need to re-visit a tendency to operationalize access and usage of preventive healthcare in terms that implicitly assume that (1) whether having a “usual source of care” is always beneficial for disadvantaged patients, and (2) patients ascribe a singular type and amount of trust toward all the healthcare workers at their treatment sites.

The biographies of unauthorized immigrant Latina mothers in this study offered a multidimensional perspective on the meaning of safety-net healthcare usage. These respondents called my attention to the number of serial and simultaneous organizational domains they had been involved in over long periods of time amid a shared legal status which formally excluded them from many public resources available to other poor families. These narratives did not allow me to simply identify respondents as occupying a particular orientation toward safety-net healthcare usage (i.e., an attitude of distrust and behavior of avoidance vs. attitude of trust and behavior of usage) at a specific point in time. Respondents’ preferences for cost-saving across multiple organizational domains rather than fully utilizing one particular safety net healthcare organization as a “usual source of care” were striking as they were situated within multifarious transportation barriers, persistent language barriers, long wait times, and complex and contradictory organizational eligibility criteria.

The multidimensionality of healthcare system usage has not been adequately considered in the extant scholarly discourse on poor families' barriers to safety net welfare and healthcare, but would perhaps not be surprising to ethnographers studying the life course experiences of disadvantaged groups (see Burton 2014) or some scholars of health inequality who have investigated coping and resilience strategies in relation to cumulative disadvantage processes (Watkins-Hayes, Pittman-Gay, and Beaman 2012). Understanding how and why unauthorized immigrant women seek to use available fragmented resources strategically across multiple organizational domains instead of fully availing themselves to a usual source of care provides important and necessary insights about healthcare usage and health-seeking behavior as well as about life course cumulative disadvantage processes in low-income populations.

#### **4.6.3 Frailties, resilience, and managing treatments and risks**

These respondents' remarks prompted me to attend to their frailties and resilience. These frailties included possible mental health problems, lifetime experiences of abuse, and myriad challenges stemming from intergenerational experiences of poverty and uncertainty that pervade their lives and ultimately shaped their healthcare/welfare-usage behaviors. Overall, they pursued healthcare and welfare resources afforded by fragmented organizational domains as tools to achieve an improved hoped-for life for their children marked by less uncertainty and upward socioeconomic and health mobility. Moreover, the mothers in this sample were

somewhat complacent about allowing themselves to have limited usage of the health-promoting resources to which they had access. Strategic and selective usage of a few particular resources made sense to them as they juggled transportation barriers, precarious employment conditions, and some physical and mental health needs that felt more pressing to address than others as they sought to be the best mothers they could be at the present moment.

For the respondents in this study, some medications were important enough to pursue even if they meant exposure to risks associated with a potentially violent ex-partner to secure enough money to pay for a prescribed treatment; other medications and treatments were seen as too expensive, less important, or simply not worth it. In the words of one interview respondent, “it’s cheaper to die than it is to go to the doctor...it would be easier to pay for a funeral than it would be to pay for a medical bill for the family.” The mothers in this study saw some mental health treatment resources as essential as they sought to face everyday hardships, while others “[could] wait until my work schedule allows” in the words of one mother. Those who did not adhere to prescribed health treatments recognized that they were not engaging in ideal health behaviors and understood their deviance in light of the knowledge that scarce and uncertain household resources needed to be strategically invested in ways that fully benefited their children. In other words, neither health literacy nor attitudes about the importance of health varied across adherents and non-adherents, underscoring the need

for scholars to continue to study disadvantaged populations in ways that provide alternatives to overly-simplified accounts which “reify moral boundaries that make people appear caricaturized” (Rios 2015: 307; see also Hannerz 2004; Small 2015).

Renewed attention is needed by social scientists, policymakers, and healthcare practitioners to understand and better develop strategic interventions to expand the availability of material resources, mitigate the cumulative health effects of social disadvantage, and provide additional mental health resources to complement the coping strategies and resilience already present among disadvantaged populations.

#### **4.6.4 Study limitations and additional areas for future research**

Findings indicating that some patients who had built up trust for healthcare workers over time and used a wider variety of organizational resources rather than only its primary care services during a period of particularly salient deportation threat raise additional questions regarding healthcare access and usage rates. During surges in deportation threat, do the rates of missed primary care appointments diverge from usage of non-healthcare resources offered by safety net settings such as yoga, health classes, or community gardens? In the wider ethnography from which this study draws, lower rates of appointment attendance among unauthorized migrant patients in relation to other patient populations was identified as a consistently-held belief expressed across interviews with healthcare providers, nurses, and “street-level” administrative support staff. However, healthcare workers also believed that there were no differences in usage

rates for non-appointment resources during periods of deportation threat. A limitation of this study is that it did not verify whether this pattern was the case. Future research should address this limitation by analyzing usage data over time, and should explore relationships between healthcare systems trust, coping resources, and usage of different kinds of mental and physical health resources.

This study documented the importance of subjective experiences of social support in how mothers sought to mitigate deportation threat and accumulating social disadvantages. Those who expressed a stronger sense of positive social support from their partners also indicated less anxiety about the potential for deportation, while those who felt more isolated also tended to be more worried about the potential for their deportation to lead to additional hardships for their children. However, another limitation of this study is that it relied on data which was collected from a relatively small sample of women which was not linked to data from men. Future research should build on these insights by exploring the cognitions surrounding deportation threat, safety-net resource usage, and hopes for the future held by unauthorized immigrant women in relation to those held by their male co-parents. Investigating the biographies and sense of agency among different family structures could better situate important gender and family structure differences in how subjective cognitions relate to "real" deportability risks (i.e., unauthorized or authorized parents and children, partners or ex-



partners, and subjective social support or isolation, following Derby's 2016 sampling logic).

This study focused on the experiences of Latina mothers as they interacted with a private primary care safety net clinic. While I argue that this is an under-explored empirical domain, a limitation of this study is that it did not document perceptions of how interacting with a private nonprofit clinic may be similar or different from interactions with public organizations. Future research may build on the insights from this study and address this gap by investigating the extent to which the strategies for using primary healthcare resources to mitigate deportation threat are similar or different among established patients at federally-qualified health centers. For example, the wider ethnography on private healthcare safety net organizations from which this study drew contained information documenting organizational leaders' negative attitudes about and avoidance of entering into collaborative partnerships with public safety net organizations. Private nonprofit organizational leaders consistently sought to avoid entering into partnerships with public health and welfare safety net organizations. Patients learned about private safety net resources via institutionalized referrals to collaborating organizations, while they learned about the availability of public resources only through informal channels. Therefore, comparing the cognitions of disadvantaged populations across public- and private-organizational environments may further clarify (1) how they simultaneously traverse multiple institutional domains given the possible

existence of different kinds of organizational collaboration networks across public and private safety net organizations (and perhaps organizational networks characterizing distinct “public safety nets” and “private safety nets”) and (2) how they might strategically leverage organizational resources to mitigate deportation threat in public clinics differently than in private nonprofit settings.

This study documented the importance of subjective experiences of spousal social support in how mothers sought to mitigate deportation threat and the accumulation of social disadvantage. Those who expressed a stronger sense of positive social support received from their partners also indicated less anxiety about the potential for deportation, while those who felt more isolated also tended to be more worried about the potential for their deportation to lead to additional hardships for their children. Another limitation of this study is that it did not collect data on the cognitions of the partners, ex-partners, or co-parents of the female respondents whose perspectives and experiences informed this study’s findings and conclusions. Future research should build on these insights by exploring the cognitions surrounding deportation threat, safety-net resource usage, and hopes for children’s’ futures held by unauthorized immigrant women in relation to those held by their partners, ex-partners, and co-parents. Investigating the biographies and sense of agency across different family structures could better situate important gender and family structure differences in how subjective cognitions relate to “real” deportability risks across policing regimes and

geographic contexts (Dreby 2016; De Genova 2002) (i.e., unauthorized or authorized parents and children, partners or ex-partners, and perceived social support or isolation; see Dreby 2016 for helpful insights regarding a sampling logic for to capture important variations in family legal status configurations for “deportability”).

Future studies investigating how low-income men and women use fragmented health and welfare resources to mitigate disadvantage and uncertainty would also do well to also draw on a wider range of data sources, including not only in-depth interviews and ethnographic data, but also longitudinal medical, administrative, and financial records across multiple organizational domains. A limitation of the present study is that it relied on interviews and ethnographic data drawn from one field site alone, and did not draw on medical, administrative, or financial records. Wherry (2017:57-58) queries how “normative standards” about spending during important life-stage transitions become manifest in individual budgeting behaviors among low-income families. Future researchers would benefit from a line of questioning that presses beyond traditional measures of financial well-being. Annual household income, for example, may not accurately reflect the resources available to particular individuals within households, as the mothers in this study often only had limited or no access to their partner’s financial resources. Analyzing longer-term treatment trajectories captured in EMR data and fluctuations in income and spending may provide a lens for researchers to clarify the potential existence of causal links between differences in

relative levels of deportation threat (over time and across urban/rural, established/new immigrant destinations) and within-person changes in health condition, income, spending, and healthcare and welfare system usage.

#### **4.6.5 Implications for organizational practice and social policy**

During temporal periods marked by salient deportation threat, healthcare organizations may find it beneficial to better tailor their services to the unique social hardships faced by unauthorized immigrants. Changing practices within organizations to better “invest” in the quality of preventive healthcare resources provided to this population may mitigate the adverse long-term accumulating health and mobility effects of broad-based social exclusion, leading to fewer and less-costly health interventions at later ages.

A less-restrictive set of immigration policies—characterized by decreases in deportations and expanded eligibility to a wider array of public resources—is expected to lead to higher usage of health-promoting safety net resources and improved health and mobility conditions for disadvantaged immigrant families. With less-restrictive immigration policies and an expansion of safety-net welfare and health resource, migrants may need fewer and less-costly health interventions as they age. Additionally, if the U.S.-born children of immigrants are afforded improved conditions earlier in life, they may be more likely to attain upward class mobility and need fewer and less costly health interventions later in life (Yoshikawa 2011:120f; Dreby 2012). In this way,

changing policies to be more inclusive of disadvantaged immigrant families may lead to long-term savings in government health spending (Schroeder 2007).

Mounk (2017) suggests that welfare policies making the receipt of aid "conditional on good behavior" are wrongheaded and counterproductive, and suggests that policies should seek to empower the poor to take responsibility for themselves and those around them. The mothers in this study, determined in their efforts to mitigate adversity and realize a better life for their families, underscore the need for policymakers to craft legislation reflecting the reality "that even society's neediest members seek to exercise genuine agency" (Mounk 2017). Integrating and expanding the scope of healthcare safety net resources available for low-income and uninsured families may be a step towards realizing these kinds of policies and empower poor families to better mitigate the cumulative health effects of social disadvantage.

## 5 Conclusion

The three studies in this dissertation documented linkages between everyday experiences of inequality and organizational processes, workplace encounters, and broader life course trajectories. These studies reveal that everyday experiences of inequality—at the level of organizations, workers, and patients—are a prominent feature of safety net healthcare delivery. Informed by theoretical insights that safety net usage may be viewed as a life course “event” with the potential to disrupt or exacerbate cumulative health disadvantage processes, I linked longitudinal ethnographic data on a healthcare safety net organization with cross-sectional patient interview data. Together, this approach provided a snapshot into how changing organizational systems may relate to the subjective experiences of longer-term processes of inequality unfolding in patients’ everyday lives. Continuing to build on this previously under-explored area of research has the potential to generate important insights to clarify the ways inequality continues to be reproduced through social institutions and more systematically evaluate the role of institutional efforts to mitigate longitudinal health disparities.

Findings from the three empirical studies both underscored and clarified the potential for future research to generate important insights advancing the state of social scientific knowledge on the role of healthcare safety net organizations in the cumulative health disadvantage experiences of low-income adults. Taken together, these three studies reveal that as low-income and uninsured adults seek to navigate local healthcare

safety-net organizations, their experiences of cumulative health disadvantage are powerfully shaped by federal- and state-level policies surrounding healthcare and welfare mediated through organizational practices. These processes may contribute to the proliferation of social inequalities along the intersecting axes of race/ethnicity, gender, and class. At the same time, adverse policy effects and processes generating disadvantage may be counteracted by the actions of organizational actors that operate through locally situated processes embedded within particular settings.

Unauthorized Latino/a adults made up a sizeable and growing proportion of CHC patients, and because they were formally excluded from many governmental sources of public assistance, they faced overall higher levels of acute socioeconomic hardships than other groups. These hardships compounded and were exacerbated as fears of deportation may have led some of these patients to minimize the degree to which CHC workers knew about their legal status. Future research should seek to situate the perspectives and healthcare seeking behaviors of unauthorized Latino men and women in relation to temporal periods of immigration policy enforcement “surges” in the community. During “surges” as compared to other times marked by less salient deportation threat, do Latina/o patients more frequently miss appointments and attempts made by healthcare workers to establish contact? If so, how do these behaviors relate to their everyday experiences of compounding inequality, and what alternative strategies do they use to mitigate uncertainty in these periods?

These findings underscore the importance of further efforts to investigate how organizational processes unfold in the everyday lives of patients to contribute to intersectional disparities in long-term health trajectories. Specifically, efforts are needed to clarify the role of organizational logics in private nonprofit clinics, especially as patients' strategies for navigating these settings may be uniquely structured relative to public safety-net organizations. Future research, for example undertaken in a comparative study introducing a federally qualified health center as a comparison case, will provide the opportunity to further validate and refine the theorization developed by these three studies. Specifically, introducing this comparison case will enable a more systematic investigation of the relationship between organizational processes and broader contextual conditions in the New Immigrant Destination setting in which these organizations are embedded.

This dissertation underscores the importance of investigating the role of interactions between individuals and dynamic institutions over time in shaping the reproduction of inequality across the life course. Findings documented in these three studies highlight the ways contextual factors in patients' everyday lives intersect with organizational processes in clinical settings and relate to cumulative health disadvantage.

In each of these studies, findings indicate that actors in healthcare safety net clinics may mitigate the stratifying effects of broader processes conferring social



disadvantage through their employment of targeted interventions. However, organizations may also contribute to the reproduction of inequality when they distribute resources according to the relative racial/ethnic, gender, and class status social position of the low-income and uninsured patients treated in these settings. Findings from Chapter 2 suggest that organizational features in place at the time of these low-income and uninsured adults' transitions into "patient" status in the healthcare safety net structure patient socialization experiences and may shape longer-term healthcare treatment trajectories. It is important for researchers to reckon with the possibility that organizational processes set in place before the time of a patient's first encounter with a healthcare provider may powerfully structure long-term treatment outcomes and contribute to the reproduction of racial/ethnic health disparities.

Chapter 3 and Chapter 4 provide challenges for future researchers to consider as they investigate the role of safety-net healthcare organizations in relation to patient health disparities that unfold over time. Findings from Chapter 3 indicate that workers sometimes deviate from formal organizational policies governing patient care and that the organizational policies themselves change over time. Both kinds of heterogeneity—among worker practices undertaken at a particular point in time, and over time as formal organizational policies change—may powerfully contribute to long-term patient health trajectories. Therefore, future investigations of safety-net healthcare treatment

outcomes ought to carefully consider the sources of heterogeneity that unfold at the worker- and organization-level.

Findings from Chapter 4 indicate that organizational practices are only one aspect of patient clinical outcomes. Future research should continue to contextualize clinical encounters within social processes unfolding over time in patients' everyday lives. Doing so may, for example, help scholars and policymakers better understand the social sources of barriers to establishing a usual source of care and what types of interventions are more or less likely to address these barriers. If, as findings from Chapter 4 suggests, disparities between unauthorized Latino immigrants and non-Hispanic Whites in establishing a usual source of care may be more closely linked to access exclusions than health literacy, then policy interventions to ease treatment access restrictions, expand access to public assistance, and/or provide a pathway to citizenship for unauthorized immigrants are likely to be more effective in reducing disparity than educational interventions aimed to improve health literacy and behavior at the level of individual patients.

Health researchers may build on the knowledge generated by these three studies by further investigating three key sites. First, future work should systematically investigate the relationship between the experiences of low-income adults and their families. Fielding interviews of the male partners or ex-partners of the women sampled in Chapter 4, for example, may generate important clarifying insights regarding the role

of family process in shaping the extent to which women and men take on diverging strategies for preventive health treatment.

Second, future research should more systematically analyze the role of “place” in shaping the contextual features surrounding the implementation of policy reforms (e.x.: partial Medicaid expansion across states) and organizational practices (e.g., healthcare delivery in urban/rural settings, southern states in comparison to other regions, New Immigrant Destinations versus Established Immigrant Destinations).

Third, future work should compare the mechanisms shaping resource distribution within particular settings in comparative perspective, assessing how disadvantaged patients approach public versus private healthcare safety-net organizations, and the extent to which these kinds of organizations share commonalities or diverge in terms of the scope and quality of their patient treatment over time and distribution of patient referrals to medical specialists and health-promoting welfare resources.

## Appendix A: Worker Interview Guide

1. Please tell me about how you came to work here. What did you do before doing the kind of work you currently do here? Did you serve in another role here? Did you work or volunteer somewhere else? How is working here in the capacity you currently do different from other roles you've taken on here, or other places in which you've worked?
2. Tell me about your role here at [clinic name]. Can you walk me through a typical day at work, like yesterday or today?
3. Tell me more about the patients here. How would you describe the patient population? [Probes: what racial/ethnic groups are represented in the patient population?] How does the patient population here compare to that of other healthcare settings in which you've had experience? What kinds of barriers to accessing health care exist for patients who are seen here?
4. Tell me about early experiences you had with working with this patient population. What did you do well? What did you learn that you needed to change?
5. Tell me about the last time you interacted with a patient in this clinic. Was this interaction similar to how you normally interact with patients here? Are these interactions similar to the kinds you've engaged in other roles you've held or other places you've worked, if you've worked in a healthcare setting before?
6. You mentioned that there are [Black, Latino, and White—use their words to describe these groups] patients in this setting. Can you recall the last interaction you had with a [Black] patient? Are there common conditions or life situations you see among [Black] patients that you treat here? [Repeat these questions for each group identified; probe for interactions with any group they did not mention.]
7. Can you tell me about times when you notice that patients trust you and times when you notice that patients do not seem to trust you? How do you know when patients trust you?
8. What would you change about how things are run around here to improve the quality of care for patients? [Probes: More time with individual patients? Less time with individual patients so more patients can be seen? More language translation resources? Other kinds of resources or services?]
9. Can you tell me about a time when you were frustrated with a patient who came here? Tell me about what happened. Is there anything you wish they would have known or done differently?

10. Can you think of a time when you were frustrated with the way a patient was being treated? Tell me about what happened. What do you wish would have been done differently?
11. Since you've been here, knowing what you know now, is there anything you'd change about the resources this clinic provides or the way it cares for patients?
12. Tell me how this clinic compares to other healthcare settings and clinics like it. Compared to clinics like it, in what ways is this clinic unique? What does it do well? What are some things that could be made better in the way this clinic works, day-to-day?
13. Those are all the questions I have for you today. Thank you very much for sharing your time with me. Is there anything else you think I should know, or anything I should keep in mind as I learn more about the roles that healthcare workers take on or how they understand working in clinics like this one?

## Appendix B: Patient Interview Guide

Thank you for meeting with me. I am very interested in hearing your thoughts about your experience at this clinic and other stories from your life so that the clinic can offer services that better meet your needs and the needs of other people in the community.

### General Health Background and Perceptions:

*Let's start out by talking about your everyday life and experiences, particularly around health.*

1. How would you rate your overall health—would you say it is excellent, very good, good, fair, or poor? Why?
2. What would you say are the most important factors (either things you do yourself, or circumstances that are out of your control) in your life that affect your health? Could you describe some of those for me?
3. Compared to others who are about your age, how would you rate your health—would you say it is better, about the same, or worse? Why?
4. Do you think your health has gotten better or worse over the last year? Why? What changes have happened in the last year that you think are related to your health now?
5. *(If they answered excellent, very good or good to Q1):* What does living a healthy life look like, for you? Can you tell me about your everyday life?
6. *(If they answered fair or poor to Q1):* If you were to imagine what you think a healthy life for you would look like, what would be some ways that it is different from your life now?

### Healthcare Seeking Behaviors:

*Let's talk a little bit now about your experiences with healthcare and how you came to this clinic.*

7. Generally, when you're sick, how do you decide when to go to the doctor or to the hospital? Can you walk me through that thought process a little?
8. Can you tell me about the last time you got sick?
  - a. Did you go to the doctor?
  - b. Did you go to this clinic or somewhere else?
9. Healthcare can sometimes be really expensive. Have you ever not gone to the doctor or the hospital because of what it might cost?
  - a. *(if Yes):* Can you tell me about that time? What happened?
  - b. *(if Yes):* Do you not go to the doctor often because of the cost?
10. Where did you get healthcare before coming to this clinic?
11. Can you tell me about how you came to be at this clinic?
  - a. What brought you here?
  - b. How long ago was that?

12. Why do you come here and not some other clinic?
  - a. Do you know about any other clinics like this one?

*Let's talk a little bit now about the healthcare of your friends and family:*

13. What kinds of issues or challenges do people in your community face that make it difficult for them to live a healthy life?
14. In general, what barriers do you think keep people from going to the doctor?
15. Some people in the community use the healthcare center here at this clinic and some people don't. Why do you think that is?
16. Do you know anyone who avoids getting healthcare because of what it might cost?
  - a. Can you tell me about them and their experiences?

*Let's talk now about your experience here at the clinic:*

17. When you first came here, what was your initial impression of this clinic?
18. How has that impression stayed the same or changed in the time you have been a patient here?
19. How does being a patient here compare to experiences you have had in other settings?
20. Tell me more about the people who work here.
  - a. Who did you interact with the last time you had an appointment?
  - b. What are your thoughts on the staff here—how would you describe them?
  - c. What about the volunteers—do you interact with them?
  - d. Do you think the volunteers differ from the staff at all, from your interactions with them?
  - e. How do the workers here compare to workers in other healthcare settings that you've been in, say another doctor's office or in the hospital?
21. What are your thoughts on the quality of communication you have with the healthcare workers here?
  - a. Do you feel like your experiences and needs are heard, understood, and addressed, or not?
22. Tell me about a positive experience or interaction you have had at this clinic
23. Tell me about an experience or interaction you've had that may not have been positive.
24. Tell me more about the other patients here at this clinic.
  - a. How would you describe them?
  - b. How do the patients here compare to the patients at other places where you've been treated?

*Let's talk about your experience at the clinic today.*

25. What happened once you got here for treatment?

- a. *Optional FU:* Did you check in at the front desk downstairs? What happens when you check-in?
- 26. What did you do after you check in?
  - a. How long did you wait?
  - b. Were there any other people in the waiting room? Tell me about them.
- 27. Once you were seen, who did you interact with?
  - a. What are you treated for?
- 28. What did the check-out process look like?
- 29. Do you think you are paying too much, too little, or about the right amount to be a patient here? Why?
- 30. Overall, how do you feel about how you have been treated at this clinic?
  - a. Have your feelings about how you have been treated changed any since you first arrived here?
- 31. Generally, do you think discrimination or unfair treatment ever happens at healthcare clinics?
  - a. Have you ever experienced discrimination at a healthcare clinic?
  - b. If so, can you tell me about the last time this happened?
  - c. Why do you think it happened?
  - d. Would you say you have ever experienced discrimination at this clinic?
  - e. Would you say that this clinic is different from other places? Why or why not?

### **Other Resources at the Clinic**

*Now I'd like to talk about some of the other things at the clinic besides their medical services.*

- 32. Besides the services provided by the medical team, can you tell me about the other resources that are offered here?
  - a. Tell me about how you use the resources here.
  - b. Do you ever get food from the clinic's community garden?
    - i. What kind of food do you get here, and how often?
  - c. Are you aware of any education or wellness classes offered by this clinic?
    - i. Do you ever go to any of these classes?
    - ii. Which ones, and how often?
  - d. Overall, what are your thoughts about the quality of the resources offered here?
  - e. Do you think people who are patients here have any unmet needs that could be met if this clinic changes the kinds of services or resources it offers?
- 33. Have you ever been referred by this clinic to a specialist?
  - a. *If yes:* Can you tell me more about that process?
- 34. Have you been referred by this clinic to other groups or services or resources in the community?



- a. If so, what services?
- 35. Does this clinic prescribe any medications for you?
  - a. Where do you pick up your medications—here or at a pharmacy somewhere else?
  - b. How much money do you spend on medications each month for you and your family?
- 36. When do you take your medication?
  - a. Do you take your medications as they are prescribed by your doctor?
  - b. Why (or why not)?

**Home Life and Relationships:**

- 37. Let's talk about what your day looks like from the time you get up to when you get here. Can you walk me through a typical day that you come to this clinic, like today?
  - a. What time did you get up?
  - b. Did you do any childcare?
  - c. Did you do any chores around the house?
  - d. Did you eat—if so, what did you eat?
  - e. How did you get here?
  - f. What time did you leave your home or work to get here on time?
  - g. Is this what usually happens when you come here?
- 38. Could you tell me a little bit about your eating habits?
  - a. What have you eaten over the last few days?
  - b. What healthy food do you and your family usually eat?
  - c. What unhealthy food do you and your family eat?
  - d. How often do you eat fruits and vegetables?
- 39. Can you tell me a little bit about your grocery shopping?
  - a. Where did you get your groceries last week?
  - b. In a normal week, how much do you spend on food from the grocery store or at restaurants?
  - c. Do you have access to enough healthy foods in your neighborhood?
- 40. Do you live by yourself or with other people?
  - a. If you live with other people, who are they?
  - b. How are you related to them?
  - c. What are the ages of the people who live with you?
- 41. Where do the people who live with you get healthcare?
  - a. Does anyone who lives with you get healthcare at this clinic? Why or why not?
  - b. *(if they mention any children):*
    - i. Where do the children go to the doctor?
    - ii. Do they have health insurance or Medicaid?

- iii. How would you describe their health?
  - iv. Do they have any health issues that you know about?
  - v. What are their strengths in being healthy? What are the challenges they face in trying to live a healthy life?
  - c. *(if they mention anyone over 65 years old):*
    - i. Where do they go to the doctor?
    - ii. Do they have health insurance or Medicare?
    - iii. How would you describe their health?
    - iv. Do they have any health issues that you know about?
    - v. What are their strengths in being healthy? What are the challenges they face in trying to live a healthy life?
42. Tell me about members of your family who do not live in your household but who are close to you.
- a. Where do they live?
  - b. Do you know where they get healthcare? If so, where do they go?
  - c. *(if they mention any children):*
    - i. Where do the children go to the doctor?
    - ii. Do they have health insurance or Medicaid?
    - iii. How would you describe their health?
    - iv. Do they have any health issues that you know about?
    - v. What are their strengths in being healthy?
    - vi. What are the challenges they face in trying to live a healthy life?
  - d. *(if they mention anyone over 65 years old):*
    - i. Where do the children go to the doctor?
    - ii. Do they have health insurance or Medicare?
    - iii. How would you describe their health?
    - iv. Do they have any health issues that you know about?
    - v. What are their strengths in being healthy?
    - vi. What are the challenges they face in trying to live a healthy life?

*Now I'd like to talk a little more about your relationships and community.*

43. From time to time, most people discuss important matters with other people. Looking back over the last six months -- who are the people with whom you discussed matters important to you?
- a. Tell me a little bit more about the people that are close to you.
  - b. Do these people know each other? [If yes:] can you describe their relationships?
44. When something good happens in your life, do you talk to anyone about it?
- a. Who do you usually talk to?
  - b. Can you remember the last time something good happened in your life?

- c. What happened?
  - d. Did you share it with anyone?
  - e. If so, who did you talk to?
45. When something challenging or bad happens in your life, do you talk to anyone about it?
- a. Who do you usually talk to?
  - b. Can you remember the last time something challenging or bad happened in your life?
  - c. What happened?
  - d. Did you share it with anyone?
  - e. If so, who did you talk to? If not, why not?
46. Do you ever talk to anyone here about any challenges in life you face?
- a. If so, who do you talk to? The last time you interacted with them, what did you talk about?
47. Do you ever talk to a chaplain or social worker here at this clinic?
- a. *If yes, ask:* The last time you interacted with them, do you remember who you talked to and what you talked about?
  - b. Was this helpful?
  - c. Why/why not?
  - d. *If no, ask,* “Do you think it would be helpful to talk to them? Why/why not?”
48. Earlier, we talked about discrimination at healthcare clinics. I’m interested in learning your thoughts about discrimination in everyday life. Generally, do you think discrimination or unfair treatment because of race, ethnicity, gender, or something else happens in everyday life?
- a. Have you ever experienced discrimination?
  - b. If so, can you tell me about the last time this happened?
  - c. Why do you think it happened?
  - d. What resources in your life did you draw on to deal with it?
49. Who talks to you when they want to share something good that happens in their life or when they need help dealing with personal challenges?
- a. What happened last time someone talked to you about something challenging?
  - b. What happened last time someone talked to you about something good?
50. How do you think other people see you as a resource in their life?
51. How would you describe your religion or spirituality?
- a. Are you part of a community of faith? What does that look like?
52. Does religion or spirituality relate to how you live a healthy life? What does that look like for you?
53. Did you know this clinic is a religious ministry?

54. Have you ever talked about religion or spirituality with anyone at this clinic, like your doctor, or a nurse, or the chaplain?
55. Have you ever prayed with anyone at this clinic?
  - a. Is this something you would be open to, or would you rather not do that here?
  - b. Why or why not?
56. Do you ever talk to a counselor, priest, preacher, or social worker somewhere else?
  - a. *If yes, ask, "The last time you interacted with them, do you remember who you talked to? What did you talk about?"*

**Demographics:**

*Now I just have a few additional questions about your background.*

57. Where were you born? [If not born in the U.S.:] When did you come to the U.S.? How did you get here? Who did you come with? Who did you leave behind? Why? What has been challenging about living here? What has been good about living here?
58. When it comes to thinking about the future for you and your family, what are you worried about? What are you hopeful about?
59. Do you live close by this clinic? How far away do you live?
60. How do you travel to get to this clinic?
61. Do you have access to a car?
  - a. [If no:] what do you do for transportation?
  - b. [If yes:] What is the make, model, and year? How many miles does it have? Is it reliable?
62. What are the primary sources of income in your household?
  - a. Do you ever have trouble paying your bills?
  - b. If so, when that happens, what do you do?
63. Do you receive food stamps, housing assistance or any other assistance from the government?
64. Have you ever interacted with any other relief organizations in Raleigh? For example, Catholic Charities, or StepUp Ministry, or Dress for Success, or Child and Family Services, or the YMCA?
 

*[If yes for any, ask follow up questions:]*

  - a. How did you hear about that group?
  - b. How often do you interact with that group?
  - c. When was the last time?
  - d. What does it look like when you interact with them?
65. Are there any other organizations or groups that you receive assistance from, to help pay with bills or something else?
66. What is the highest level of education you have completed?

*[If born outside the U.S.:]*

- a. Was your education completed in the U.S. or outside the U.S.?
67. Did you do any vocational training or study at a college/university?  
*[If yes:]*
  - a. What was the name of the school or program?
68. Are you currently employed?
  - a. *[If yes:]* What is your job? How many hours each week do you work?
  - b. *[If no:]* Is someone in your house currently employed?
69. What is your annual household income?
70. Do you have health insurance, or Medicaid, or Medicare?
71. Did you pay a federal tax penalty for not having health insurance last year? Do you know how much you had to pay?
72. Are a citizen of the United States?
  - a. *[If no:]* Do you currently have a permanent residence card or green card?
  - b. *[If no:]* Have you been granted asylum, refugee status, or temporary protection?
  - c. *[If no:]* Do you have a tourist visa, a work visa or permit, or another document to stay in the U.S. for a limited time?
  - d. *[If yes:]* Is this visa valid or has it expired?
73. What county do you live in? How long have you lived there? Where did you live before? Why did you move?
74. Can you tell me about two other people who you know that live in this county and don't have health insurance, Medicaid, or Medicare? Do they come to this clinic? Why or why not?
75. How would you describe your race or ethnicity?
76. What is your age?
77. What is your gender?

Those are all the questions I have for you today. Is there anything else you think I should know, about you or the clinic that would be useful as we talk to more people about their experiences?

Thank you very much for sharing your time with me.

## References

- Abbott, Andrew. 1992 "What do Cases do? Some Notes on Activity in Sociological Analysis." Pp. 53-82 in *What is a Case*, edited by Charles C. Ragin and Howard S. Becker. New York: Cambridge University Press.
- Abrego, Leisy J. 2011. "Legal Consciousness of Undocumented Latinos: Fear and Stigma as Barriers to Claims-Making for First- and 1.5-Generation Immigrants." *Law & Society Review* 45(2):337-370.
- Acker, Joan. 1990. "Hierarchies, jobs, bodies: A theory of gendered organizations." *Gender & Society* 4(2), 139-158.
- Almgren, Gunnar and Taryn Lindhorst. 2012. *The Safety-Net Health Care System: Health Care at the Margins*. New York: Springer.
- Armstrong, Katrina, Karima L. Ravenell, Suzanne McMurphy, and Mary Putt. 2007. "Racial/ethnic Differences in Physician Distrust in the United States." *American Journal of Public Health* 97(7):1283.
- Asad, Asad L., and Matthew Clair. 2017. "Racialized legal status as a social determinant of health." *Social Science & Medicine*. Forthcoming.
- Ayanian, John Z., Joel S. Weissman, Eric C. Schneider, Jack A. Ginsburg, and Alan M. Zaslavsky. 2000. "Unmet Health Needs of Uninsured Adults in the United States." *Journal of the American Medical Association* 284(16):2061-2069.
- Blumer, Herbert. 1955. "Attitudes and the Social Act." *Social Problems* 3(2):59-65.
- Boezeman, Edwin J., and Naomi Ellemers. 2008. "Volunteer recruitment: The role of organizational support and anticipated respect in non-volunteers' attraction to charitable volunteer organizations." *Journal of Applied Psychology* 93(5):1013-1026.
- Bonilla-Silva, Eduardo. 1997. "Rethinking Racism: Toward a Structural Interpretation." *American Sociological Review* 62(3):465-480.
- Bonilla-Silva, Eduardo. 2001. *White Supremacy and Racism in the Post-Civil Rights Era*. Boulder: Lynne Reinner.

- Bonilla-Silva, Eduardo. 2004. "From Bi-Racial to Tri-Racial: Towards a New System of Racial Stratification in the USA." *Ethnic and Racial Studies*, 27(6):931-950.
- Bonilla-Silva, Eduardo. 2017. *Racism without Racists: Color-Blind Racism and the Persistence of Racial Inequality in America*. Lanham: Rowman & Littlefield.
- Bookbinder, Sylvia H., and Charles J. Brainerd. "Emotion and False Memory: The Context-Content Paradox." *Psychological Bulletin* 142(12):1315-1351.
- Boulware, L. Ebony, Lisa A. Cooper, Lloyd E. Ratner, Thomas A. LaVeist, and Neil R. Powe. 2003. "Race and Trust in the Health Care System." *Public Health Reports* 4(118):358-365.
- Bourdieu, Pierre. 1977. *Outline of a Theory of Practice*. New York: Cambridge University Press.
- Bourdieu, Pierre. 1990. *The Logic of Practice*. Stanford: Stanford University Press.
- Bourdieu, Pierre, and Jean-Claude Passeron. "Reproduction in Society, Education and Culture." Translated by Richard Nice. London: Sage.
- Bourdieu, Pierre, and Loïc Wacquant. *An invitation to reflexive sociology*. Chicago: University of Chicago Press.
- Bradley, Cathy J., Bassam Dahman, and Lindsay M. Sabik. 2014. "Differences in Emergency Colorectal Surgery in Medicaid and Uninsured Patients by Hospital Safety Net Status." *The American Journal of Managed Care* 21(2):161-170.
- Braveman, Paula, and Laura Gottlieb. 2014. "The social determinants of health: it's time to consider the causes of the causes." *Public Health Reports* 129(1):19-31.
- Bridges, Khiara. 2011. *Reproducing Race: An Ethnography of Pregnancy as a Site of Racialization*. Berkeley: University of California Press.
- Brown, Elizabeth J., Shreya Kangovi, Christopher Sha, Sarah Johnson, Casey Chanton, Tamala Carter, and David T. Grande. 2015. "Exploring the Patient and Staff Experience with the Process of Primary Care." *The Annals of Family Medicine* 13(4):347-353.
- Brown, Tyson H., and Taylor W. Hargrove. 2013. "Multidimensional Approaches to Examining Gender and Racial/Ethnic Stratification in Health." *Women, Gender, and Families of Color* 1(2):180-206.

- Brown, Tyson H. and Taylor Hargrove. 2017. "Psychological Mechanisms Underlying Older Black Men's Health." *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*. Forthcoming.
- Brown, Tyson H., Angela M. O'Rand, and Daniel E. Adkins. 2012. "Race-Ethnicity and Health Trajectories: Tests of Three Hypotheses across Multiple Groups and Health Outcomes." *Journal of Health and Social Behavior* 53(3):359-377.
- Burton, Linda M. 2007. "Childhood Adulthood in Economically Disadvantaged Families: A Conceptual Model." *Family Relations* 56(4):329-345.
- Burton, Linda M. 2014. "Seeking Romance in the Crosshairs of Multiple-Partner Fertility: Ethnographic Insights on Low-Income Urban and Rural Mothers." *The ANNALS of the American Academy of Political and Social Science* 654(1):185-212.
- Burton, Linda M., and M. Belinda Tucker. 2009. "Romantic Unions in an Era of Uncertainty: A Post-Moynihan Perspective on African American Women and Marriage." *The Annals of the American Academy of Political and Social Science* 621(1):132-148.
- Chan, Kitty S., Darrell J. Gaskin, Gniesha Y. Dinwiddie, and Rachael McCleary. 2012. "Do Diabetic Patients Living in Racially Segregated Neighborhoods Experience Different Access and Quality of Care?" *Medical Care* 50(8):692-699.
- Clark, Rebecca L., Jennifer E. Glick, and Regina M. Bures. 2009. "Immigrant Families over the Life Course: Research Directions and Needs." *Journal of Family Issues*, 30(6):852-872
- Cockerham, William C. 2005. "Health Lifestyle Theory and the Convergence of Agency and Structure." *Journal of health and social behavior* 46(1):51-67.
- Coleman, James S. 1988. "Social Capital in the Creation of Human Capital." *American Journal of Sociology* 94:95-120.
- Dannefer, Dale. 1987. "Aging as Intracohort Differentiation: Accentuation, the Matthew Effect, and the Life Course." *Sociological Forum* 2(2).
- Dannefer, Dale. 2003. "Cumulative Advantage/Disadvantage and the Life Course: Cross-Fertilizing Age and Social Science Theory." *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences* 58(6):327-337.



- De Genova, Nicholas P. 2002. "Migrant 'Illegality' and Deportability in Everyday Life." *Annual Review of Anthropology* 31(1):419-447.
- Diemer, Matthew A., Rashmita S. Mistry, Martha E. Wadsworth, Irene López, and Faye Reimers. 2013. "Best Practices in Conceptualizing and Measuring Social Class in Psychological Research." *Analyses of Social Issues and Public Policy* 13(1):77-113.
- DiPrete, Thomas A., and Gregory M. Eirich. 2006. "Cumulative Advantage as a Mechanism for Inequality: A Review of Theoretical and Empirical Developments." *Annual Review of Sociology*: 271-297.
- Donato, Katharine M., and Leslie Ann Rodríguez. 2014. "Police Arrests in a Time of Uncertainty: The Impact of 287 (g) on Arrests in a New Immigrant Gateway." *American Behavioral Scientist* 58(13):1696-1722.
- Dreby, Joanna. 2015. *Everyday Illegal: When Policies Undermine Immigrant Families*. Oakland: University of California Press.
- Durand, Jorge, Douglas S. Massey, and Karen A. Pren. 2016. "Double Disadvantage: Unauthorized Mexicans in the US labor market." *The ANNALS of the American Academy of Political and Social Science* 666(1):78-90.
- Eagle, David E., Collin Mueller, Rae Jean Proeschold-Bell and Monica Corbitt Rivers. 2017. "The Barriers to the Economic and Occupational Attainment of Black Professionals in a Predominantly White Organization: The Case of United Methodist Clergy." Duke University working paper.
- Edin, Kathryn, and Laura Lein. 1997. "Work, Welfare, and Single Mothers' Economic Survival Strategies." *American Sociological Review* 62(2):253-266.
- Edin, Kathryn, and Laura Lein. 1998. "The Private Safety Net: The Role of Charitable Organizations in the Lives of the Poor." *Housing Policy Debate* 9(3):541-573.
- Elder, Glen H. 1994. "Time, Human Agency, and Social Change: Perspectives on the Life Course." *Social Psychology Quarterly* 57(1):4-15.
- Elder Jr, Glen H., and Richard C. Rockwell. 1979. "The Life-Course and Human Development: An Ecological Perspective." *International Journal of Behavioral Development* 2(1):1-21.
- Faist, Thomas. 1995. "Ethnicization and Racialization of Welfare-State Politics in Germany and the USA." *Ethnic and Racial Studies* 18(2):219-250.

- Finch, Brian Karl, and William A. Vega. 2003. "Acculturation Stress, Social Support, and Self-Rated Health among Latinos in California." *Journal of Immigrant Health* 5(3):109-117.
- Hitlin, Steven, and Monica Kirkpatrick Johnson. 2015. "Reconceptualizing Agency within the Life Course: The Power of Looking Ahead." *American Journal of Sociology* 120(5):1429-1472.
- Frean, Molly, Jonathan Gruber, and Benjamin D. Sommers. 2017. "Premium Subsidies, the Mandate, and Medicaid Expansion: Coverage Effects of the Affordable Care Act." *Journal of Health Economics* 53:72-86.
- Garip, Filiz. 2017. *On the Move: Changing Mechanisms of Mexico-U.S. Migration*. Princeton: Princeton University Press.
- Garrett-Peters, Raymond. 2009. "'If I Don't Have to Work Anymore, Who Am I?': Job Loss and Collaborative Self-Concept Repair." *Journal of Contemporary Ethnography* 38(5):47-583.
- Garrett-Peters, Raymond, and Linda M. Burton. 2015. "Reframing Marriage and Marital Delay Among Low-Income Mothers: An Interactionist Perspective." *Journal of Family Theory & Review* 7(3):242-264.
- Garrow, Eve, and Yeheskel Hasenfeld. 2010. "Theoretical approaches to human service organizations." Pp. 33-58 in *Human Services as Complex Organizations*, edited by Yeheskel Hasenfeld. Los Angeles: Sage.
- Gee, Gilbert C., and Chandra L. Ford. 2011. "Structural Racism and Health Inequities." *Du Bois Review: Social Science Research on Race* 8(1): 115-132.
- Goffman, Erving. 1963. *Behavior in Public Places*. New York: The Free Press.
- Goffman, Erving. 1967. *Interaction Ritual*. New York: Anchor Books.
- Gómez, Laura E. and Nancy López. 2013. *Mapping "Race": Critical Approaches to Health Disparities Research*. New Brunswick: Rutgers University Press.
- Gonzales, Roberto G. 2011. "Learning to be Illegal: Undocumented Youth and Shifting Legal Contexts in the Transition to Adulthood." *American Sociological Review* 76(4):602-619.

- Goodrick, Elizabeth, and Trish Reay. 2011. "Constellations of institutional logics: Changes in the professional work of pharmacists." *Work and Occupations* 38(3): 372-416.
- Gupta, Shivani, Alison T. Brenner, Neda Ratanawongsa, and John M. Inadomi. 2014. "Patient Trust in Physician Influences Colorectal Cancer Screening in Low-Income Patients." *American Journal of Preventive Medicine* 47(4): 417-423.
- Hacker, Jacob S. 2002. *The Divided Welfare State: The Battle over Public and Private Social Benefits in the United States*. New York: Cambridge University Press.
- Hacker, Jacob S. "Privatizing Risk without Privatizing the Welfare State: The Hidden Politics of Social Policy Retrenchment in the United States." *American Political Science Review* 98.2 (2004): 243-260.
- Hagan, Jacqueline, Nestor Rodriguez, Randy Capps, and Nika Kabiri. "The Effects of Recent Welfare and Immigration Reforms on Immigrants' Access to Health Care." *International Migration Review* 37.2 (2003): 444-463.
- Hallett, Tim. "The Myth Incarnate: Recoupling Processes, Turmoil, and Inhabited Institutions in an Urban Elementary School." *American Sociological Review* 75.1 (2010): 52-74.
- Hannerz, Ulf. 2004. *Foreign News: Exploring the World of Foreign Correspondents*. Chicago: The University of Chicago Press.
- Harding, David J., Cheyney C. Dobson, Jessica J.B. Wyse, and Jeffrey D. Morenoff. 2016. "Narrative change, narrative stability, and structural constraint: The case of prisoner reentry narratives." *American Journal of Cultural Sociology*: 1-44.
- Harrell, Shelly P. "A multidimensional conceptualization of racism-related stress: Implications for the well-being of people of color." *American journal of Orthopsychiatry* 70.1 (2000): 42-57.
- Hartry, Allison S. "Gendering Crimmigration: The Intersection of Gender, Immigration, and the Criminal Justice System." *Berkeley Journal of Gender, Law & Justice* 27.1 (2012).
- Hasenfeld, Yeheskel. 2009. *Human Services as Complex Organizations*. Los Angeles: Sage.

- Hayward, Mark D., and Bridget K. Gorman. "The Long Arm of Childhood: The Influence of Early-Life Social Conditions on Men's Mortality." *Demography* 41.1 (2004): 87-107.
- Hayward, Mark D., Robert A. Hummer, Chi-Tsun Chiu, César González-González, and Rebeca Wong. "Does the Hispanic Paradox in US Adult Mortality Extend to Disability?." *Population Research and Policy Review* 33, no. 1 (2014): 81-96.
- Heintzman, John, Miguel Marino, Megan Hoopes, Steffani Bailey, Rachel Gold, Courtney Crawford, Stuart Cowburn, Jean O'Malley, Christine Nelson, and Jennifer E. DeVoe. 2014. "Using Electronic Health Record Data to Evaluate Preventive Service Utilization among Uninsured Safety Net Patients." *Preventive Medicine* 67:306-310.
- Holden, Craig D., Jie Chen, and Rada K. Dagher. 2015. "Preventive Care Utilization among the Uninsured by Race/Ethnicity and Income." *American Journal of Preventive Medicine* 48(1): 13-21.
- Horton, Sarah. 2006. "The Double Burden on Safety Net Providers: Placing Health Disparities in the Context of the Privatization of Health Care in the US." *Social Science & Medicine* 63(10): 2702-2714.
- Miles, Matthew B., and A. Michael Huberman. *Qualitative Data Analysis: An Expanded Sourcebook*. sage, 1994.
- Irving, Shelley K. 2008. "State Welfare Rules, TANF Exits, and Geographic Context: Does Place Matter?" *Rural Sociology* 73(4): 605-630.
- Jackson, John L. 2001. *Harlemworld: Doing Race and Class in Contemporary Black America*. Chicago: University of Chicago Press.
- Kalleberg, Arne L. 2009. "Precarious work, insecure workers: Employment relations in transition." *American Sociological Review* 74(1): 1-22.
- Kangovi, Shreya, Frances K. Barg, Tamala Carter, Judith A. Long, Richard Shannon, and David Grande. 2013. "Understanding why patients of low socioeconomic status prefer hospitals over ambulatory care." *Health Affairs* 32(7): 1196-1203.
- Konczal, Lisa, and Leah Varga. 2012. "Structural violence and compassionate compatriots: immigrant health care in South Florida." *Ethnic and Racial Studies* 35(1):88-103.

- Laiteerapong, Neda, James Kirby, Yue Gao, Tzy-Chyi Yu, Ravi Sharma, Robert Nocon, and Sang Mee Lee. 2014. "Health Care Utilization and Receipt of Preventive Care for Patients Seen at Federally Funded Health Centers Compared to Other Sites of Primary Care." *Health Services Research* 49(5): 1498-1518.
- LaRossa, Ralph. 2004. "Grounded Theory Methods and Qualitative Family Research." *Journal of Marriage and Family* 67(4): 837-857.
- Link, Bruce G., and Jo Phelan. "Social Conditions as Fundamental Causes of Disease." *Journal of health and social behavior* (1995): 80-94.
- Lipsky, Michael. 2010. *Street-Level Bureaucracy: Dilemmas of the Individual in Public Service*. New York: Russell Sage Foundation.
- Mahmoudi, Elham, and Gail A. Jensen. 2014. "Has Medicare Part D Reduced Racial/Ethnic Disparities in Prescription Drug Use and Spending?" *Health Services Research* 49(2): 502-525.
- Markus, Hazel R. and Paula M. L. Moya. 2010. *Doing Race: 21 Essays for the 21st Century*. New York: Norton.
- Marrow, Helen B. 2009. "Immigrant Bureaucratic Incorporation: The Dual Roles of Professional Missions and Government Policies." *American Sociological Review*, 74(5): 756-776.
- Marrow, Helen B. 2011. *New Destination Dreaming: Immigration, Race, and Legal Status in the Rural American South*. Stanford: Stanford University Press.
- Marrow, Helen B., and Tiffany D. Joseph. "Excluded and Frozen Out: Unauthorized Immigrants' (Non) Access to Care After US Health Care Reform." *Journal of Ethnic and Migration Studies* 41.14 (2015): 2253-2273.
- Rhodes, Scott D., Lilli Mann, Florence M. Simán, Eunyoung Song, Jorge Alonzo, Mario Downs, and Emma Lawlor. 2015. "The Impact of Local Immigration Enforcement Policies on the Health of Immigrant Hispanics/Latinos in the United States." *American Journal of Public Health* 105(2):329-337.
- Meyer, John W., and Brian Rowan. 1977. "Institutionalized Organizations: Formal Structure as Myth and Ceremony." *American Journal of Sociology* 83(2):340-363.
- Moffitt, Robert A. 2015. "The Deserving Poor, the Family, and the US Welfare System." *Demography* 52(3):729-749.

- Moffitt, Robert A., Andrew J. Cherlin, Linda M. Burton, and P. Lindsay Chase-Lansdale. 2002. "Disadvantage among Families Remaining on Welfare." *Joint Center for Poverty Research Policy Brief*.
- Morgan, Kimberly J., and Andrea Louise Campbell. 2011. *The Delegated Welfare State: Medicare, Markets, and the Governance of Social Policy*. New York: Oxford University Press.
- Mueller, Collin W., and Bryce J. Bartlett. 2017. "US Immigration Policy Regimes and Physical Disability Trajectories among Mexico–US Immigrants." *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*. Forthcoming.
- Musa, Donald, Richard Schulz, Roderick Harris, Myrna Silverman, and Stephen B. Thomas. 2009. "Trust in the Health Care System and the Use of Preventive Health Services by Older Black and White Adults." *American Journal of Public Health* 99(7):1293-1299.
- O'Neil, Kevin, and Marta Tienda. 2014. "Age at Immigration and the Incomes of Older Immigrants, 1994–2010." *Journals of Gerontology Series B: Psychological Sciences and Social Sciences* 70(2):291-302.
- O'Rand, Angela M. 1996. "The Precious and the Precocious: Understanding Cumulative Disadvantage and Cumulative Advantage over the Life Course." *The Gerontologist* 36(2): 230-238.
- O'Rand, Angela M., and Jenifer Hamil-Luker. 2005. "Processes of Cumulative Adversity: Childhood Disadvantage and Increased Risk of Heart Attack across the Life Course." *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences* 60(2):117-124.
- Ocasio, William, Jeffrey Loewenstein, and Amit Nigam. 2015. "How Streams of Communication Reproduce and Change Institutional Logics: The Role of Categories." *Academy of Management Review* 40(1): 28-48.
- Oliver, Melvin L., and Thomas M. Shapiro. 2006. *Black Wealth, White Wealth: A New Perspective on Racial Inequality*. New York: Routledge.
- Omi, Michael, and Howard Winant. *Racial Formation in the United States*. 2014. New York: Routledge.

- Pache, Anne-Claire, and Filipe Santos. 2010. "When Worlds Collide: The Internal Dynamics of Organizational Responses to Conflicting Institutional Demands." *Academy of Management Review* 35(3):455-476.
- Pache, Anne-Claire, and Filipe Santos. 2013. "Inside the Hybrid Organization: Selective Coupling as a Response to Competing Institutional Logics." *Academy of Management Journal* 56(4):972-1001.
- Pearlin, Leonard I., Scott Schieman, Elena M. Fazio, and Stephen C. Meersman. 2005. "Stress, Health, and the Life Course: Some Conceptual Perspectives." *Journal of Health and Social Behavior* 46(2):205-219.
- Perrow, Charles. 1986. *Complex Organizations*. New York: Random House.
- Perry, Brea L., Kathi L.H. Harp, and Carrie B. Oser. 2013. "Racial and Gender Discrimination in the Stress Process: Implications for African American Women's Health and Well-Being." *Sociological Perspectives* 56(1):25-48.
- Pfeffer, Fabian T., and Florian R. Hertel. "How has Educational Expansion Shaped Social Mobility Trends in the United States?" *Social Forces* 94.1 (2015): 143-180.
- Rank, Mark R., and Thomas A. Hirschl. 2002. "Welfare Use as a Life Course Event: Toward a New Understanding of the US Safety Net." *Social Work* 47(3):237-248.
- Ray, Victor E. 2017. "A Theory of Racialized Organizations." University of Tennessee-Knoxville working paper.
- Reay, Trish, and C. Robert Hinings. 2009. "Managing the Rivalry of Competing Institutional Logics." *Organization Studies* 30(6):629-652.
- Reid, Joan A. 2012. "Exploratory Review of Route-Specific, Gendered, and Age-Graded Dynamics of Exploitation: Applying Life Course Theory to Victimization in Sex Trafficking in North America." *Aggression and Violent Behavior* 17(3):257-271.
- Reskin, Barbara F. 2000. "Getting it Right: Sex and Race Inequality in Work Organizations." *Annual Review of Sociology* 26:707-709.
- Richards, Michael R., Brendan Saloner, Genevieve M. Kenney, Karin Rhodes, and Daniel Polsky. 2014. "Access Points for the Underserved: Primary Care Appointment Availability at Federally Qualified Health Centers in 10 States." *Medical Care* 52(9):818-825.

- Rios, Victor M. 2015. "On the Run: Fugitive Life in an American City by Alice Goffman." *American Journal of Sociology* 121(1):306-308.
- Rock, Paul. 2001. "Symbolic Interactionism and Ethnography." Pp. 26-38 in *Handbook of Ethnography*, ed. Paul Atkinson, Amanda Coffey, Sara Delamont, John Lofland, and Lyn Lofland. Los Angeles: Sage.
- Sainsbury, Diane. 2006. "Immigrants' Social Rights in Comparative Perspective: Welfare Regimes, Forms in Immigration and Immigration Policy Regimes." *Journal of European Social Policy* 16(3): 229-244.
- Sandri, Kelly J., Inge Verdenius, Mitchell J. Bartley, Britney M. Else, Christopher A. Paynter, Beth E. Rosemergy, and George D. Harris. 2014. "Urban and Rural Safety Net Health Care System Clinics: No Disparity in HPV4 Vaccine Completion Rates." *PLoS One* 9(5).
- Schwalbe, Michael, Daphne Holden, Douglas Schrock, Sandra Godwin, Shealy Thompson, and Michele Wolkomir. 2000. "Generic Processes in the Reproduction of Inequality: An Interactionist Analysis." *Social Forces* 79(2):419-452.
- Sewell, William H. 1992. "A Theory of Structure: Duality, Agency, and Transformation." *American Journal of Sociology* 98(1):1-29.
- Shavers, Vickie L., Pebbles Fagan, Dionne Jones, William MP Klein, Josephine Boyington, Carmen Moten, and Edward Rorie. 2012. "The State of Research on Racial/Ethnic Discrimination in the Receipt of Health Care." *American Journal of Public Health* 102(5): 953-966.
- Shim, Janet K. 2010. "Cultural Health Capital: A Theoretical Approach to Understanding Health Care Interactions and the Dynamics of Unequal Treatment." *Journal of Health and Social Behavior* 51(1):1-15.
- Shuey, Kim M., and Andrea E. Willson. 2008. "Cumulative Disadvantage and Black-White Disparities in Life-Course Health Trajectories." *Research on Aging* 30(2):200-225.
- Silva, Jennifer M. 2013. *Coming Up Short: Working-Class Adulthood in an Age of Uncertainty*. New York: Oxford University Press.
- Skrtic, Thomas. 2003. "An Organizational Analysis of the Overrepresentation of Poor and Minority Students in Special Education." *Multiple Voices for Ethnically Diverse Exceptional Learners* 6(1):41-57.



- Small, Mario L. 2015. "De-Exoticizing Ghetto Poverty: On the Ethics of Representation in Urban Ethnography." *City & Community* 14(4):352-358.
- Soss, Joe, Richard C. Fording, and Sanford Schram. 2011. *Disciplining the Poor: Neoliberal Paternalism and the Persistent Power of Race*. Chicago: University of Chicago Press.
- Steenland, Brian. 2006. "Cultural Categories and the American Welfare State: The Case of Guaranteed Income Policy." *American Journal of Sociology* 111(5):1273-1326.
- Stone, Lisa C., Blake Boursaw, Sonia P. Bettez, Tennille Larzelere Marley, and Howard Waitzkin. 2015. "Place as a Predictor of Health Insurance Coverage: A Multivariate Analysis of Counties in the United States." *Health & Place* 34:207-214.
- Strauss, A., and J. Corbin. 1998. *Basics of Qualitative Research Techniques*. New York: Sage.
- Streib, Jessi. 2011. "Class Reproduction by Four Year Olds." *Qualitative Sociology* 34(2):337.
- Streib, Jessi. 2015. *The Power of the Past: Understanding Cross-Class Marriages*. New York: Oxford University Press.
- Tach, Laura, and Kathryn Edin. 2017. "The Social Safety Net after Welfare Reform: Recent Developments and Consequences for Household Dynamics." *Annual Review of Sociology*. Forthcoming.
- Ocasio, William, and P. H. Thornton. 2008. "Institutional Logics." *The SAGE Handbook of Organizational Institutionalism*: 99-129.
- Thornton, Patricia H., William Ocasio, and Michael Lounsbury. 2012. *The Institutional Logics Perspective: A New Approach to Culture, Structure, and Process*. New York: Oxford University Press.
- Turco, Catherine. 2012. "Difficult Decoupling: Employee Resistance to the Commercialization of Personal Settings." *American Journal of Sociology* 118(2): 380-419.
- Umberson, Debra, Kristi Williams, Patricia A. Thomas, Hui Liu, and Mieke Beth Thomeer. 2014. "Race, Gender, and Chains of Disadvantage: Childhood Adversity, Social Relationships, and Health." *Journal of Health and Social Behavior* 55(1):20-38.

- Vaidya, Varun, Gautam Partha, and Jennifer Howe. 2011. "Utilization of Preventive Care Services and their Effect on Cardiovascular Outcomes in the United States." *Risk Management and Healthcare Policy* 4:1-7.
- Van Ryn, Michelle, and Steven S. Fu. 2003. "Paved with Good Intentions: Do Public Health and Human Service Providers Contribute to Racial/Ethnic Disparities in Health?" *American Journal of Public Health* 93(2):248-255.
- Vargas, Robert. 2016. "How Health Navigators Legitimize the Affordable Care Act to the Uninsured Poor." *Social Science and Medicine* 165: 263-270.
- Viruell-Fuentes, Edna A. 2007. "Beyond acculturation: immigration, discrimination, and health research among Mexicans in the United States." *Social science & medicine* 65(7): 1524-1535.
- Viruell-Fuentes, Edna A., Patricia Y. Miranda, and Sawsan Abdulrahim. 2012. "More than Culture: Structural Racism, Intersectionality Theory, and Immigrant Health." *Social Science & Medicine* 75(12): 2099-2106.
- Wacquant, Loïc. 2009. *Punishing the Poor: The Neoliberal Government of Social Insecurity*. Durham: Duke University Press.
- Waitzkin, Howard, Robert L. Williams, John A. Bock, Joanne McCloskey, Cathleen Willging, and William Wagner. (2002) "Safety-Net Institutions Buffer the Impact of Medicaid Managed Care: A Multi-Method Assessment in a Rural State." *American Journal of Public Health* 92(4):598-610.
- Warren, John T. 2001. "Doing Whiteness: On the Performative Dimensions of Race in the Classroom." *Communication Education* 50(2):91-108.
- Watkins-Hayes, Celeste. 2009. *The New Welfare Bureaucrats: Entanglements of Race, Class, and Policy Reform*. Chicago: University of Chicago Press.
- Watkins-Hayes, Celeste. 2011. "Race, Respect, and Red Tape: Inside the Black Box of Racially Representative Bureaucracies." *Journal of Public Administration Research and Theory* 21(2):233-251.
- Watkins-Hayes, Celeste. 2013. "The Micro Dynamics of Support Seeking: The Social and Economic Utility of Institutional Ties for HIV-Positive Women." *The ANNALS of the American Academy of Political and Social Science* 647(1):83-101.

- Watkins-Hayes, Celeste, LaShawnDa Pittman-Gay, and Jean Beaman. 2012. "Dying from' to 'Living with': Framing Institutions and the Coping Processes of African American Women Living with HIV/AIDS." *Social Science & Medicine* 74(12):2028-2036.
- West, Candace, and Don H. Zimmerman. 1987. "Doing Gender." *Gender & Society* 1(2):125-151.
- White, Kellee, Jennifer S. Haas, and David R. Williams. 2012. "Elucidating the Role of Place in Health Care Disparities: The Example of Racial/Ethnic Residential Segregation." *Health Services Research* 47(3):1278-1299.
- Willson, Andrea E., Kim M. Shuey, and Glen H. Elder. 2007. "Cumulative Advantage Processes as Mechanisms of Inequality in Life Course Health." *American Journal of Sociology* 112(6):1886-1924.
- Wingfield, Adia H. 2008. "Racializing the Glass Escalator: Reconsidering Men's Experiences with Women's Work." *Gender & Society* 23(1):5-26.
- Wingfield, Adia Harvey. 2013. *No More Invisible Man: Race and Gender in Men's Work*. Philadelphia: Temple University Press.
- Wingfield, Adia Harvey, and Renée Skeete Alston. 2014. "Maintaining Hierarchies in Predominantly White Organizations: A Theory of Racial Tasks." *American Behavioral Scientist* 58(2):274-287.
- Wooten, Melissa E., and Lucius Couloute. 2017. "The production of racial inequality within and among organizations." *Sociology Compass* Forthcoming.
- Zhang, Xuanping, Kai McKeever Bullard, Edward W. Gregg, Gloria L. Beckles, Desmond E. Williams, Lawrence E. Barker, Ann L. Albright, and Giuseppina Imperatore. 2012. "Access to Health Care and Control of ABCs of Diabetes." *Diabetes Care* 35(7):1566-1571.

## Biography

Collin William Mueller was born in Houston, Texas on August 4, 1986. He began his academic career at Rice University, where he completed his B.A. (Religious Studies with Honors) in May 2009. He received both his M.A. from the Sociology Department and his M.Div. from the Divinity School at Duke University in May 2015. He received his Ph.D. from Duke University in 2017. He has published a number of articles, including “Immigration Policy Regimes and Physical Disability Trajectories Among Mexico-U.S. Immigrants” in *The Journals of Gerontology: Social Sciences* (with Bryce Bartlett) and “Listening to Religious Music and Mental Health in Later Life” in *The Gerontologist* (with Matt Bradshaw, Christopher Ellison, and Qijuan Fang). He has received a number of grants and fellowships, including a Doctoral Dissertation Research Improvement Award through the National Science Foundation, a Community Action Research Initiative Grant from the Sydney S. Spivack Program in Applied Social Research and Social Policy through the American Sociological Association, a Student Research Award through the Society for the Scientific Study of Religion, a Constant H. Jacquet Research Award through the Religious Research Association, a John Wesley Fellowship through A Foundation for Theological Education, a Student Travel Award through the Behavioral and Social Sciences Section of the Gerontological Society of America, a Center for the Study of Philanthropy and Voluntarism Dissertation Fellowship through the Sanford School of Public Policy at Duke University, an Aleane

Webb Dissertation Research Award through Duke University, a Dissertation Research Travel Award through Duke University, a Sociology Graduate Student Research Grant through Duke University, three Summer Research Fellowships through the Graduate School at Duke University, a Ph.D. Student Fellowship through the Department of Sociology at Duke University, a Leadership in an Aging Society Program Fellowship through the Center for the Study of Aging and Human Development at Duke University, and a Duke Scholarship through the Divinity School at Duke University.